

Response ID ANON-F5GY-YFXC-N

Submitted to Consultation on the Draft Ethical Framework for Resource Allocation In Times of Scarcity
Submitted on 2020-06-23 17:19:39

Your details

What is your name?

Name:

Contact details

Email:

What is your organisation?

Organisation:

What is your role?

Please enter your role here:

GP

Which interest group do you best represent?

Other (please use following free text)

Use this text box if you selected 'Other':

Health Care provider

Feedback on the Framework

The Framework captures the ethical tensions in resource allocation in times of scarcity

Agree

Please outline your reasons.:

yes to a degree. However, it give little mention to primary care providers and staff who actually provide most of the services. There needs to be equitable funding for providers to provide a safe service for staff and patients. Where a large funder provides inequitable funding to provide a service and a small provider is to provide the service, there is a power imbalance. This could result in inequitable outcomes- small provider decides not to provide service or needs to charge co-payments to provide sustainability of service thereby limiting patients access to assessment and management. I note geneva convention on human rights says:

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:

(a) Remuneration which provides all workers, as a minimum, with:

(i) Fair wages and equal remuneration for work of equal value without distinction of any kind, in particular women being guaranteed conditions of work not inferior to those enjoyed by men, with equal pay for equal work;

Efforts need to be made to ensure allocation of resources to small providers that is equitable and non decrimatory and providers are sustainable.

The Framework helps decision-makers understand the ethical implications of making decisions

Agree

Please outline your reasons.:

see above comment.

also there is little mention of rural patients who always have equity of access issues.

The Framework helps decision-makers consider equity when responding to COVID-19

Agree

Please outline your reasons.:

see comments above

NEAC seek feedback on the Te Tiriti Principles and their application to resource allocation decisions

Please provide feedback:

Please provide any further comments, feedback or proposed changes for NEAC to consider when finalising the Framework

Feedback::

Broader Pandemic Ethics - Your Views

What area(s) of pandemic ethics should NEAC take into account during the review of Getting Through Together?

In the context of pandemics, what ethical guidance do you think would be beneficial for decision-makers, communities and individuals?:

Publishing submissions and privacy

Publishing submissions

You may publish this submission

Official Information Act responses

Remove my personal details from responses to Official Information Act requests

Commercially sensitive information

This submission does not contain commercially sensitive information

If your submission contains commercially sensitive information, please let us know where.:

Response ID ANON-F5GY-YFX8-A

Submitted to Consultation on the Draft Ethical Framework for Resource Allocation In Times of Scarcity
Submitted on 2020-07-03 00:54:14

Your details

What is your name?

Name:

Contact details

Email:

What is your organisation?

Organisation:

Australasian College For Emergency Medicine

What is your role?

Please enter your role here:

Member of the ACEM COVID guideline authoring group, Ethics section

Which interest group do you best represent?

Other (please use following free text)

Use this text box if you selected 'Other':

Medical College

Feedback on the Framework

The Framework captures the ethical tensions in resource allocation in times of scarcity

Strongly Agree

Please outline your reasons.:

Well articulated, but also very clear in the language around equity and the importance of awareness of social determinants of health in decision making.

The Framework helps decision-makers understand the ethical implications of making decisions

Agree

Please outline your reasons.:

Good discussion of potential outcomes of decisions of resource allocation

The Framework helps decision-makers consider equity when responding to COVID-19

Agree

Please outline your reasons.:

Excellent discussion of equity and the underpinning determinants of health, and the concept that an 'equal' decision may not be equal when a particular group comes from a disadvantaged place. I feel some of the language could be stronger around this, and I would omit 'There must be sufficient evidence to demonstrate that these factors are predictive of prognosis if they are to be used in allocation decisions' on page 6 - it weakens the argument of the preceding paragraph.

NEAC seek feedback on the Te Tiriti Principles and their application to resource allocation decisions

Please provide feedback:

Please provide any further comments, feedback or proposed changes for NEAC to consider when finalising the Framework

Feedback::

Excellent, comprehensive and necessary framework. A few typos and grammatical errors.

Broader Pandemic Ethics - Your Views

What area(s) of pandemic ethics should NEAC take into account during the review of Getting Through Together?

In the context of pandemics, what ethical guidance do you think would be beneficial for decision-makers, communities and individuals?:

The ethics around technologies, and in particular the use of technology in end-of-life care; it should be considered a basic human right to have access to communication with loved ones at the end of life - even if by telephone and other means. Specific guidance around public health strategies such as social distancing, mask-wearing, and other infection control strategies for the greater good. Ethical guidance around the principles of risk perception vs actual risk and mental health in both the community and health care workers.

Publishing submissions and privacy

Publishing submissions

You may publish this submission

Official Information Act responses

Remove my personal details from responses to Official Information Act requests

Commercially sensitive information

This submission does not contain commercially sensitive information

If your submission contains commercially sensitive information, please let us know where.:

Response ID ANON-F5GY-YFX9-B

Submitted to Consultation on the Draft Ethical Framework for Resource Allocation In Times of Scarcity
Submitted on 2020-07-15 13:41:16

Your details

What is your name?

Name:

Contact details

Email:

What is your organisation?

Organisation:

New Zealand Nurses Organisation

What is your role?

Please enter your role here:

Which interest group do you best represent?

Other (please use following free text)

Use this text box if you selected 'Other':

Nursing Professional Association and Union

Feedback on the Framework

The Framework captures the ethical tensions in resource allocation in times of scarcity

Strongly Agree

Please outline your reasons.:

The framework makes it clear that resource allocation principles compete with one another, and that when resources are scarce, all the principles cannot be evenly applied. All people are deserving of care, but clinical need often requires that some individuals are prioritised for treatment. These tensions are confronted all the time in clinical environments where staff and resources are limiting. In addition, the framework acknowledges the additional tension of combating indigenous and disability bias in the allocation of resources.

The Framework helps decision-makers understand the ethical implications of making decisions

Strongly Agree

Please outline your reasons.:

The ICU, PPE and vaccine examples illustrate how applying resources on the basis of one allocation principle, conflicts with allocation according to another principal. The same applies to resource allocation according to Te Tiriti principles.

The Framework helps decision-makers consider equity when responding to COVID-19

Strongly Agree

Please outline your reasons.:

This framework provides excellent guidance on how to apply the equity lens to allocation of resources. Also, it outlines the importance of making decisions that do not exacerbate inequity.

We supported the framework robustness in achieving equity and in particular, for elaborating on these issues with the examples of allocation of personal protective equipment and of clinical resources in the Intensive care unit.

NEAC seek feedback on the Te Tiriti Principles and their application to resource allocation decisions

Please provide feedback:

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. Accordingly, we applaud the inclusion of principles for allocation of resources according to the articles of Te Tiriti. Maori and Pacific people are disproportionately represented among the worse health outcomes in New

Zealand. The application of this framework across health and disability services in New Zealand, not just in times of scarcity, would assist with reducing the current disparities in morbidity and mortality.

Please provide any further comments, feedback or proposed changes for NEAC to consider when finalising the Framework

Feedback::

Collection of feedback from members

From NZ College of Critical Care Nurses

NZCCCN have read through this framework and found it robust for a guideline for allocation in times of scarcity. There was excellent acknowledgement for combating indigenous and disability bias in the allocation of resources.

From Cancer Nurses College NZNO

Thank-you for the opportunity to comment on National Ethics Advisory Committee document: Ethical Framework for Resource Allocation in Times of Scarcity. This is acknowledged as a high level framework developed to help clinicians, nurses and hospital administrators and public health policy makers optimise distribution and prioritisation of vital resources in times of scarcity and is as a result of the international pandemic COVID-19.

New Zealand is in the enviable position of having had time to prepare resources to cope with the possibility of an overwhelming drain on health care resources, which fortunately we have not experienced.

Countries such as Spain and Italy have not had this luxury and have been overwhelmed with large numbers of patients all requiring access to health resources. In any emergency situation, triage will be performed to allocate resource based upon where there will be most benefit. This, ideally, is done by an experienced triage team in a clinical setting and will be based upon clinical need, irrelevant of socio-economic factors such as race, age, gender, ethnicity, religious beliefs, disability etc.

The document should acknowledge DHB disaster plans which comment on the skill of the team required to perform these triage decisions, whether this is a pandemic, major incident or natural disaster, and will include the readiness and ability of the DHB to accommodate potential patient surges which will impact on the day to day functioning of the health system.

Broader Pandemic Ethics - Your Views

What area(s) of pandemic ethics should NEAC take into account during the review of Getting Through Together?

In the context of pandemics, what ethical guidance do you think would be beneficial for decision-makers, communities and individuals?:

Nurses, midwives, health care workers and kai mahi hauora may have to care for individuals who meet the case definition for COVID-19. Careful planning can help reduce the impact of COVID-19 or a pandemic, but nurses, midwives, health care workers and kai mahi hauora must still remain mindful of both their rights and responsibilities.

Under the Health and Safety Workplace Act 2015, employees have the right to refuse to perform work if they believe carrying out the work would expose them, or any other person, to a serious risk to health or safety due to immediate or imminent exposure to a hazard.

There are specific steps in this legislation that must be carried out before refusing to perform work. For example, employees must attempt to resolve the issue with the employer as soon as practicable and, should the matter remain unresolved, the employee must have reasonable grounds for believing a serious risk is attached to continuing such work.

Reasonable grounds for such belief will be established if a health and safety representative has advised the employee that carrying out the work would expose them, or another person, to serious risk. The NZNO document 'Guideline: Obligations in a pandemic or disaster, 2016' could be a useful reference.

In addition it might be beneficial to include ethical guidance on personal responsibility during a pandemic. This might include the obligation to have a pandemic preparedness kit, to maintain social distance, hand washing and coughing etiquette for example, but also to be considerate with regards to purchasing supplies so as not to limit supply of goods for other consumers.

A further recommendation for the framework regards the use of digital technologies. Virtual care assessment, for example via telehealth, needs to be guided according to the same principals of resource allocation as other clinical resources. Phone triage or self-triage tools would be the first contact people have with their health care providers. Individuals may or may not have access to digital technology such as a mobile device and internet access. The use of a mobile device to enable observations will be crucial to the assessment. It will be essential to ensure that the move to digital health does not further exacerbate inequity.

Ethical application of digital technology such as virtual care and patient assessments needs to also take into consideration any limitations due to physical and mental health, cognition, function, and other clinical issues. In addition, it is vital to employ digital technology in a way that preserves the confidentiality of personal health information and falls within all relevant privacy legislation.

Publishing submissions and privacy

Publishing submissions

You may publish this submission

Official Information Act responses

Remove my personal details from responses to Official Information Act requests

Commercially sensitive information

This submission does not contain commercially sensitive information

If your submission contains commercially sensitive information, please let us know where.:



Public Consultation on the Draft Ethical Framework for Resource Allocation In Times of Scarcity - National Ethics Advisory Committee

07/07/2020 11:50 am

02

History

This message has been replied to.

Kia ora!

We have reviewed your draft Ethical Framework for Resource Allocation In Times of Scarcity - National Ethics Advisory Committee and believe it is a good description of the issues confronting the Government for the pandemic and its aftermath.

Our only comment is that with regard to the Treaty it is that we believe it should be seen as a whole and that the articles are inter related. For this reason we believe that Te Tiriti o Waitangi recognises that Māori have the right to determine their own destiny (tino rangatiratanga) and that without self-determination Māori cannot achieve full equity with our fellow citizens (Oritenga). In other words Tino rangatiratanga (self determination) is the path to Oritenga (equity).

Senior Policy Analyst / Kai-tātari
Kaupapa Heie Tōmua
National Office



Te Puni Kōkiri

Te Puni
Kōkiri House,
143 Lambton
Quay,
Wellington
6011, New
Zealand
PO Box 3943,
Wellington
6140, New
Zealand



Te Puni
Kōkiri

[Website](#)



Kōkiri
Magazine

16 July 2020



HEALTH QUALITY & SAFETY
COMMISSION NEW ZEALAND
Te Kaitiaki Takekōwhiri

PO Box 25496
Wellington 6146
New Zealand

T: +64 4 901 6040
F: +64 4 901 6079
E: info@hqsc.govt.nz
W: www.hqsc.govt.nz

Ethics
Health System Improvement and Innovation
Ministry of Health

Tēnā koe

Thank you for the opportunity for the Health Quality & Safety Commission (the Commission) to provide feedback on NEAC's draft "*Ethical Framework for Resource Allocation in Times of Scarcity*".

As requested, the Commission's feedback is formatted to respond to the questions NEAC have asked:

1. *Whether the Framework captures the ethical tensions in resource allocation in times of scarcity.*

The ethical tensions and examples of the application of the principles are clearly outlined in the document, particularly the 'general allocation guidance' section.

If this document continues to be a stand-alone document, then we suggest the addition of "during a Covid-19 pandemic" to the title for easier identification and access.

2. *Whether the Framework helps decision-makers understand the ethical implications of making decisions.*

The document contains information that would be a refresher for clinicians, administrators and policy makers to inform future planning and the revision of 'Getting Through Together: Ethical Values for a pandemic'. The document (at 29 pages) is not a 'quick guide' for frontline workers which would have been particularly useful as the Covid-19 pandemic was emerging. A simple guide including the development of a flowchart or decision tree, that could be used by, for example, an RMO working in intensive care during the night would be welcomed by the sector.

The term 'hospital administrators' is used in the document, an indication of who is included in this category, e.g. managers or team leaders, would be helpful.

The document advises that health service institutions establish an ethics 'decision-making group' at the local level and outlines the tasks the group should undertake; this may be a significant challenge for smaller providers and organisations who may not have enough capacity or capability to form such a group. Given the rapidly changing situation that may

occur during a pandemic it is assumed that decisions will be needed 'out of office hours' and the provision of a national 0800 ethics hotline could be considered in future pandemic plans. The setting up and maintenance of regional groups could also be considered.

Guidance for primary, community and aged residential care sectors should be included in the document, e.g. how would aged residential care providers use this document to inform them on the prioritising of the use of personal protective equipment (PPE).

3. *Whether the Framework helps decision-makers consider equity when responding to Covid-19.*

The Commission is pleased to see that equity has been placed as a central tenant to ethical resource decision-making and allocation.

It is also good to see that equity is as central to determining PPE distribution priorities to protect marginalised groups and prevent or improve inequities. It is also good that you have articulated the need to ensure that listening to marginalised groups regarding what they need and how best to distribute resources is essential to ethical decision-making and allocation of resources.

There is an opportunity to emphasise that equity for Māori is a responsibility in the context of Te Tiriti o Waitangi articles/principles, specifically in relation to Article 3 - Oritetanga – Equity for Māori. It is suggested that there is further opportunity to link the Te Tiriti focus in the document more explicitly with the equity focus. This would support more flow and connection of the Te Tiriti responsibilities throughout the document and more clearly link these key considerations through to decisions and actions.

The Commission encourages the articulation of the importance of working with iwi and Māori health groups to ensure the needs of Māori are met and Māori are involved in or control distribution within their communities.

There is further opportunity to widen the context in this document to ensure discussion is inclusive of primary care, community care, NGO settings and whanau settings and not so centrally or exclusively focussed on hospital resources.

4. *Feedback on the Te Tiriti Principles and their application to resource allocation decisions.*

The Commission strongly supports the articulation of the Te Tiriti principles and their application to ethical resource allocation. We also acknowledge and agree to it being articulated right up front in the document and again in the framework. We suggest considering the inclusion of an understanding of the Articles of Te Tiriti o Waitangi and specifically Article 2 - Tinorangatiratanga; Maori authority and decision-making and the Crown's obligations to ensuring this occurs in the context of any ethical framework e.g. has Māori worldview concepts and considerations been sought, acknowledged and been used to inform? This is a requirement firstly of any ethical framework and could be further emphasised regarding ethical pandemic planning, decision making and resource allocation.

5. *Any further comments and suggested changes for NEAC to consider for the final draft.*

The use of a broader approach, rather than focussing just on specific pandemics or diseases such as Covid-19. While we appreciate the added impetus, the pandemic brought to, the development of the document we believe extending the advice to resource scarcity to more 'everyday' challenges, e.g. the scarcity of a drug or supply of oxygen would be more widely understood.

Inclusion of information on approaches to advanced care planning and developing shared goals of care that can be implemented prior to or during a pandemic. We are aware of the work of the Nelson Marlborough DHB that developed shared goals of care forms for use in all aged care facilities.

6. *What ethical issues or areas of work you think should be covered in a substantial review of Getting Through Together.*

The largest untapped resource in the health and disability service is that of the people who use those services, in this case we refer to consumers. The framework would have greater relevance if consumers were included in the notion of 'partnership', resources and decision-making processes and they are not 'outsiders looking in' at this very important time. For example, the decision-making group example should specifically state that consumers need to be sitting at the 'table at the time' and be full members of this group rather than just have patients' perspectives included, or ensuring appropriate communication with the public about decisions (refer page 23).

The inclusion of descriptions of the ethical tensions and examples of the application of the principles for primary care, aged residential care and the homeless.

A section on the requirements for all practitioners to meet the requirements of their registration under the Health Practitioners Competency Assurance Act to practice in an ethical manner.

Again thank you this opportunity, if you require any clarification please contact

Ngā mihi nui

Chief Executive



neac

National Ethics Advisory Committee

Kāhui Matatika o te Motu

**Ethical Framework for
Resource Allocation in
Times of Scarcity**

June 2020

National Ethics Advisory Committee | Kāhui Matatika o te Motu

Citation: National Ethics Advisory Committee. 2020. *Ethical Framework for Resource Allocation in Times of Scarcity*. Wellington: Ministry of Health.

Published in June 2020 for the National Ethics Advisory Committee – Kāhui Matatika o te Motu by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN: 978-XXXX (online)
HP XXXX

This publication is available on the National Ethics Advisory Committee website:
www.neac.health.govt.nz

neac
National Ethics Advisory Committee
Kāhui Matatika o te Motu

Contents

National Ethics Advisory Committee – Kāhui Matatika o te Motu	1
Members of NEAC.....	1
Members of the secretariat.....	1
Acknowledgements	1
Introduction.....	2
Key features of the COVID-19 virus.....	2
Te Tiriti o Waitangi.....	2
A focus on equity.....	3
Increasing risk through unequal distribution and exposure to the determinants of health.....	3
Indigenous health inequities in New Zealand.....	4
Human rights.....	4
Ethical principles.....	5
Introduction.....	5
Tensions between the principles.....	5
Allocation of resources.....	10
Resources	10
Clinical resources	10
Public health resources	11
Support service resources	11
Making decisions.....	11
The decision-making process	11
Establishing a decision-making group	12
General allocation guidance.....	13
Should COVID-19 patients be prioritised over patients without COVID-19 in resource allocation?	13
How will resource allocation impact electives and routine health care?	13

Should the standard of care for patients change in an epidemic?.....	14
How will data be collected and shared?.....	14
What are organisations' obligations?.....	14
Example 1: Intensive care unit allocation	15
Introduction.....	15
Applying the principles.....	15
Prioritising the people most in need.....	15
Getting the most out of resources.....	15
Achieving equity.....	16
All people are equally deserving of care.....	16
General considerations.....	16
Example 2: Personal protective equipment allocation.....	20
Introduction.....	20
Applying the principles.....	20
Prioritising the people most in need.....	20
Getting the most from the resources.....	20
Achieving equity.....	21
All people are equally deserving of care.....	22
General considerations.....	22
Example 3: Vaccine allocation	24
Introduction.....	24
Applying the principles.....	24
Getting the most from the resources.....	24
Prioritising the people most in need.....	24
Achieving equity.....	25
All people are equally deserving of care.....	25
General considerations.....	25
Bibliography.....	27

National Ethics Advisory Committee – Kāhui Matatika o te Motu

The National Ethics Advisory Committee – Kāhui Matatika o te Motu (NEAC) is an independent advisor to the Minister of Health (the Minister). The members of NEAC are appointed by the Minister and bring expertise in ethics, health and disability research, health service provision and leadership, public health, epidemiology, law, Māori health and consumer advocacy.

NEAC published *Getting Through Together: Ethical values for a pandemic in 2007* (NEAC 2007). *Ethical Framework for Resource Allocation in Times of Scarcity* builds on the work of *Getting Through Together*.

Members of NEAC

Maureen Holdaway, Kahu McClintock, Wayne Milos, Neil Pickering, Liz Richards, Hope Tupara, Dana Wensley, Gordon Jackman, Mary-Anne Woodnorth.

Members of the secretariat

Nic Aagaard, Rob McHawk, Hayley Robertson, Martin Kennedy, Matthew Poulson, Tristan Katz.

Acknowledgements

The ethical framework for making resource allocation decisions was developed by NEAC, with support and advice from Angela Ballantyne, Kiri Dargaville, Cheree Shortland-Nuku and Helen Whongji.

Introduction

As a result of COVID-19, we are experiencing an increasing demand on our health care system and its resources. Clinical professionals and public health officials are likely to have to make decisions about situations they have never experienced before. This 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.

NEAC emphasises 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 and does not consider all potentially scarce resources or all potential decisions.

NEAC note that this document is in response to the COVID-19 pandemic. NEAC intend to develop this document to be more generally applicable to pandemics as part of their wider work program, which involves updating *Getting Through Together: Ethical values for a pandemic*.

Key features of the COVID-19 virus

The virus can spread from person to person through:

- close contact with an infectious person (including in the 48 hours before that infectious person exhibits symptoms of their infection)
 - contact with droplets from an infected person's cough or sneeze
 - touching objects or surfaces (such as doorknobs or tables) that have droplets from an infected person and then touching your mouth or face (Australian Government Department of Health 2020).
- COVID-19 is a new disease, so there is no existing population immunity. This means that COVID-19 can spread widely and quickly.

Symptoms of COVID-19 can range from mild illness to acute respiratory distress syndrome (ARDS). Some people will recover easily, others may get very sick very quickly, and some will die.

Te Tiriti o Waitangi

Te Tiriti o Waitangi / the Treaty of Waitangi (Te Tiriti) is one of the major sources of New Zealand's constitution. Te Tiriti creates a basis for civil government encompassing all New Zealanders. The Government continues to respond to its obligations to honour Te Tiriti. Te Tiriti mandates that Māori participate in equal partnership with the Government. To this end, Māori must have protection and receive acknowledgement of their rights and interests within their shared citizenship.

The New Zealand health and disability system has a responsibility to contribute to meeting the Crown's obligations under Te Tiriti. As an independent advisor to the Minister, this ethical framework supports the New Zealand health and disability system in meeting its obligations under Te Tiriti by drawing on the principles of Te Tiriti as articulated by the courts and the Waitangi Tribunal and considering their implications for resource allocation decisions.

Supporting the New Zealand health and disability system to meet its obligations under Te Tiriti is necessary if we are to ensure iwi, hapū, whānau and Māori communities are active partners in preventing, mitigating and managing the impacts of a pandemic or public health emergency on whānau, hapū, iwi and Māori communities (Ministry of Health 2020).

A focus on equity

Pandemics and other public health emergencies often have the biggest impact on marginalised communities. Pandemics highlight and exacerbate already existing inequities within the health system. For this reason, NEAC provides ethical guidance and notes the importance of considering equity in resource allocation. Equity recognises that different people with different levels of advantage require different approaches and resources to achieve equitable health outcomes.

Increasing risk through unequal distribution and exposure to the determinants of health

This framework recognises that every person is of equal moral worth. However, significant health inequalities exist among different groups of New Zealanders. This difference in health status between groups is influenced by socioeconomic factors and compounded by structural inequities, such as racism and discrimination. Structural inequities systematically disadvantage individuals and groups based on ethnicity and social positioning (ie, age, gender, ability). This results in the unequal distribution of power and resources and differentiated access and exposure to the acknowledged determinants of health. Research persistently shows that Māori, Pacific peoples and people from lower socioeconomic demographics experience worse health and die younger than other New Zealanders (Ministry of Health 2020).

Disabled people are of equal value and have the same rights as all other New Zealanders. Yet an underlying, pervasive and often unquestioned devaluing of disabled people exists called 'ableism'. When ableism intersects with ageism and/or racism, it can compound discrimination and specific human rights violations, deprioritisation in access to resources and poorer-quality health services.

Māori, Pacific peoples and disabled people, older people, people with intellectual and psychosocial impairments and those with chronic health

conditions, co-morbidities, dependence on ventilators and compromised immunity face are even more vulnerable during the COVID-19 pandemic.

These factors are particularly relevant when allocating clinical resources during a pandemic.

Indigenous health inequities in New Zealand

Māori experience higher rates of infectious diseases than other New Zealanders (Ballantyne 2020). For COVID-19, older people and individuals with underlying conditions are at increased risk of severe infection. Māori as a population have higher rates of chronic conditions and comorbidities and are therefore more likely to develop severe COVID-19 as a result of contracting SARS-CoV-2 infection. In addition, Māori often have more people living in their households, which places more people at risk from exposure to infectious diseases ... but conversely, more people in the household stand to benefit from preventative actions.

Human rights

This framework is underpinned by all people's right to good health, including access to necessary resources, as expressed in article 25 and

the preamble of the Universal Declaration of Human Rights (United Nations 1948).¹ Human dignity is the ultimate foundation of all human rights and fundamental freedoms.

¹ Article 25 reads: "Everyone has the right to a standard of living adequate for the health and well-being of themselves and their family, including ... medical care ...". And, in the declaration's preamble, the General Assembly of the United Nations proclaims that "... every individual and every organ of

society ... shall strive ... by progressive measures, national and international, to secure their universal and effective recognition."

Ethical principles

Introduction

This section sets out four resource allocation principles and four Te Tiriti principles (tables 1 and 2 respectively).

This framework does not prioritise the principles ethically or conceptually. However, the two sets of principles do have one important common ground: they highlight the important factors, particularly for Māori, that must be considered when allocating scarce resources. Importantly, the way they are applied will vary depending on the resource being considered, the level of scarcity and the context (clinical or public health)

Tensions between the principles

NEAC holds that having multiple principles reflecting a plurality of values is the best basis of ethical decision-making. It may be that in some circumstances different principles can be followed at the same time. For example, in some elective surgeries, prioritising those with most need and achieving the most benefit might be considered in tandem to achieve the best result. But in a pandemic (as with many other contexts), values and principles can conflict.

For example, with COVID-19, it may not be possible to achieve equity and to benefit the most people possible. As an example, in the case of intensive care unit (ICU) beds or ventilators, the decision might be made to treat those with fewer comorbidities first because this is predicted to be the best way of saving as many lives as possible. Yet, doing so may undermine equity if some groups (such as Māori or disabled people) tend to have more comorbidities than other groups to start with.

From a theoretical position, NEAC's approach fits with the idea that the different and sometimes inconsistent values and principles of ethics are *prima facie*. This means that wherever they are relevant, they are significant, but a particular value or principle may sometimes have to be sacrificed to realise another value or principle, judged of greater weight or significance in the circumstances. From a psychological standpoint, people will often feel a variety of values pulling them in different directions, experiencing internally the ethical dilemmas described later in this framework around the three examples of intensive care unit allocation, personal protective equipment allocation and vaccine allocation.

The three examples show the tensions that exist between values and principles when making difficult decisions. NEAC believes that good decision-making involves recognising, rather than ignoring, these tensions.

Table 1: Resource allocation principles

The resource allocation principles chosen reflect the important considerations that are made when prioritising scarce resources. They are in tension and must be considered in light of each resource allocation decision.

Resource allocation principle	Application to resource allocation
<p>All people are equally deserving of care</p>	<p>Each person affected by the COVID-19 pandemic in New Zealand deserves equal respect and consideration.</p> <p>Resources should not be distributed arbitrarily or withheld on the basis of individual or group characteristics that are irrelevant to the clinical prognosis, for example, including: race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation' (United Nations Committee on Economic, Social and Cultural Rights, 2009).² There must be sufficient evidence to demonstrate that these factors are predictive of prognosis if they are to be used in allocation decisions.</p> <p>Fair allocation should aim to avoid a first-come, first-served bias.</p>
<p>Getting the most from the resources</p>	<p>Resources required for the COVID-19 pandemic response must be managed responsibly, in the context of a health emergency, we should aim to allocate resources efficiently and maximise the clinical benefits.</p> <p>There are several competing interpretations of how best to measure clinical benefit, for example: to maximise lives saved, to maximise life-years saved (eg, by prioritising the young to maximise length of lives saved), to maximise the cost-effective use of resources and to prioritise essential workers (such as health care staff) so they can continue to serve and protect the public.</p>

² Note also that under the New Zealand Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations, 1984, right 2, every health consumer has the right to be free from discrimination. See: www.hdc.org.nz/your-rights/about-the-code-of-health-and-disability-services-consumers-rights

Table 2: Te Tiriti o Waitangi principles

The principles of Te Tiriti o Waitangi, as articulated by the Courts and the Waitangi Tribunal, provide the framework for how our health and disability system ought to meet its obligations under Te Tiriti in its day-to-day work. The Waitangi Tribunal's 2019 Hauora report recommends a set of principles for the primary health care system that are applicable to the wider health and disability system and are applied to resource allocation principles in table 2 below (Waitangi Tribunal 2019, pages 163–64).

Te Tiriti o Waitangi principles as set out in the Hauora report	Te Tiriti o Waitangi principles' application to the primary health care system	Te Tiriti o Waitangi principles' application to resource allocation
The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery and monitoring of primary health care.	Tino rangatiratanga requires clinicians, hospital administrators and public health policy makers to provide for Māori self-determination.	In a resource allocation setting, this means that Māori are key decision makers in the design, delivery, prioritisation and monitoring of health and disability services and the response to pandemics or public health emergencies.
The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.	Options, which requires clinicians, hospital administrators and public health policy makers to provide for and properly resource kaupapa Māori health and disability services in response to a pandemic or public health emergency.	In a resource allocation setting, this means that the health and disability system is agile in adapting and responding to the pandemic resource needs of kaupapa Māori health and disability services to be able to serve Māori communities.
The principle of active protection, which requires the Crown to act, to the fullest extent	Active protection, which requires clinicians, hospital administrators and public health	This requires the clinicians, hospital administrators and public health policy makers to prioritise

<p>Te Tiriti o Waitangi principles as set out in the Heaora report</p> <p>practicable, to achieve equitable health outcomes for Māori.</p> <p>This includes ensuring that the Crown, its agents and its Treaty partner are well informed about the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.</p>	<p>Te Tiriti o Waitangi principles: application to the primary health care system</p> <p>policy makers to act to the fullest extent practicable, to protect Māori health and achieve equitable health outcomes for Māori in response to a pandemic or public health emergency.</p>	<p>Te Tiriti o Waitangi principles: application to resource allocation</p> <p>resources to actively protect the health of the Māori population and implement approaches to equip whānau, hapū, iwi and Māori communities with the resources to undertake and respond to public health measures to prevent and/or manage the spread and transmission of disease among their people.</p>
<p>The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of primary health services. Māori must be co-designers, with the Crown, of the primary health system for Māori.</p>	<p>Partnership, which requires the clinicians, hospital administrators and public health policy makers and Māori to work in partnership in the governance, design, delivery and monitoring of the response to a pandemic or public health emergency. This contributes to a shared responsibility for achieving health equity for Māori.</p>	<p>In a resource allocation setting, this means that the health and disability system works alongside Māori leaders to enable a coordinated and united response to a pandemic or public health emergency whereby Māori have the resources to govern, design, deliver, manage and monitor a response and the impacts on Māori communities.</p>

Allocation of resources

Resources

When we don't have enough of a particular resource to meet demand, we must decide the best way to distribute that supply of resource to ensure the most effective results. Resource allocation is the mechanism we use to do this.

This framework applies to extreme measures intended to be implemented only in the worst-case scenario, in which adequate resources are not available. The application of principles and the relative weighting of different principles may differ between emergency and non-emergency situations. For example, a novel COVID-19 vaccine would still need to meet safety and efficacy standards; but it may be ethical to endorse a wide-spread immunisation programme without long-term outcome data.⁴

Ethical resource allocation should not be limited to clinical resources. There are many different kinds of resources that may become scarce

⁴ For example, the New Zealand Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulators 33(6), right 7, states that every health consumer has the right to services of an appropriate standard. (See: www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights.) However, what is 'appropriate' will be interpreted differently depending on context and the resources available.

during a pandemic. Each resource has a different risk/benefit profile and may be rationed or prioritised using a different weighting of the principles, for example, a clinical or medical context in the case of ventilators or a public health context in the case of personal protective equipment.

Support services are an additional category of essential pandemic resources and, if allocated well, they can be useful in mitigating risk for individuals and communities.

This framework could be applied to a variety of resources. Some options are listed below.⁵

Clinical resources

Treatment has burdens and benefits; the decision to allocate a clinical resource is complex and requires assessment of utility/appropriateness of medical intervention, the patient's best interests, the patient's autonomy and the principles of resource allocation. Clinical resources include access to:

- ICU
- ventilators

⁵ The options listed expand on those discussed in *Sydney Health Ethics: An Ethics Framework for Making Resources Allocation Decisions within Clinical Care: Responding to COVID-19* (University of Sydney, 2020).

- palliative care
- medications.

Public health resources

These are clearly valuable goods, typically with minimal risks or downsides. They include:

- personal protective equipment (PPE)
- diagnostics
- clinical expertise
- vaccines.

Support service resources

These are measures that can increase access to services and mitigate adverse impact. They include:

- carers visitation rights (allocating PPE to support this)
- accessible communication (public and patient)
- supported decision-making tools and services
- financial support for home careers
- interpreters
- social workers

health navigators

health and disability advocates

- rehabilitation support (given the growing evidence of disabilities associated with critical COVID-19 e.g. Post-Intensive Care Syndrome cases).

Making decisions

The decision-making process

Good decision-making processes confer legitimacy on the final decisions, even when disagreement persists, and may help to resolve ongoing disagreement. They may also help ensure that decisions include comprehensive consideration of relevant issues.

Pandemic planning decisions should be clearly consistent and underpinned by ethical values. A good decision-making process fosters public trust and goodwill towards institutions such as hospitals, leading to greater acceptance and satisfaction and fewer complaints. Such processes identify values recognised in Māori tikanga or kawa (protocol or ceremonial actions) alongside other values.

It has been suggested that 'due process requirements are inherently important because fair hearings affirm the dignity of the person' (Bayer 2007 p. 266). Good decision-making processes may be necessary in

order to show respect for people and ensure procedural fairness. As such, they may also reflect the value of tika, in the sense of acting in a way that is just and proper. Māori tikanga and mātauranga Māori may need to be considered in the context of challenging other values not just sitting alongside those values.

A wide range of views can be present when considering ethical issues, and it is common to have a lack of consensus about which values and principles are the most important on which to base a decision. This is another reason why we need to develop acceptable, fair processes.

Establishing a decision-making group⁶

NEAC recommends that a decision-making group be established in appropriate health services institutions at both the national and local level, as necessary. Each institution will need to consider the kind of membership for their decision-making group that will work best for them. Each group should include the perspectives of their particular institution's patients, Māori, disabled people, clinicians, ethicists, legal and any other relevant stakeholders who will be impacted by the decisions the group will be making. The group should:

- frequently re-evaluate their allocation criteria since the application of ethical frameworks should be a fluid process that moves back and forth along a continuum contingent on available resources and as the understanding of the spread, pathophysiology, treatment and outcomes of COVID-19 infection evolves
- determine the best way of communicating clearly and consistently to appropriate personnel about when crisis level allocation or re-allocation is and is not in effect
- take into account Te Tiriti articles and principles and their application to resource allocation
- consider plans for ensuring staff safety, maintaining clinician-to-patient ratios, training additional personnel, supporting organisational resiliency and providing support resources for staff (child care, payment, sick leave, etc.)
- ensure appropriate communication with patients, the local community and the broader general public about plans for scarce resource allocation
- maintain communication links between local and national responses.

Commenter

How realistic does NEAC think it is for each primary and secondary care provider to be able to convene such broad membership of a decision-making group at very short notice? Personally, I think this will be quite unrealistic for smaller organisations.

⁶ The recommendations in this section are based on information from *Ethical Framework and Recommendations for COVID-19 Resources Allocation* (Wipou, *Scandis* is Auckland University of Victoria Health System Ethics Committee, 2020).

In the clinical context, a key aim is to separate care and advocacy for a particular patient from the allocation decisions. This provides a level of detachment from the immediate clinical needs of each patient, better ensuring a clear and defensible decision-making process around resource allocation, thereby reducing the opportunities for accusations of bias. It also has the advantage of protecting those clinicians caring directly for patients from some of the direct stress and anxiety of being the decision-makers about allocation.

In the public health context, establishing a group allows transparency and clear communication between the national and local levels. It also ensures a clearer path to engaging with local communities.

General allocation guidance

Should COVID-19 patients be prioritised over patients without COVID-19 in resource allocation?

NEAC agrees with *Sydney Health Ethics, An Ethics Framework for Making Resource Allocation Decisions within Clinical Care: Responding to COVID-19* that there are no ethically defensible grounds to prioritise

an infected patient over any patient who is not infected (University of Sydney 2020).

How will resource allocation impact elective and routine health care?

If resources, such as clinical expertise, become scarce, it may be necessary to prioritise responding to the pandemic over non-essential interventions (elective surgeries, cancer screening) that can be postponed. However, such a decision could have significant health impacts for individuals and should not be taken lightly. The decision is grounded in two interrelated justifications. The first is to reduce the spread of COVID-19. The second is to prepare for a potential swell of COVID-19 patients.

Postponing non-essential interventions necessarily involves a trade-off between the harm caused by postponing routine care and the potential harm of health systems being overwhelmed. Decisions relating to postponing non-essential interventions, need to be continually reassessed. National instructions to prohibit non-essential services may cause harm if they are applied to organisations in regions that do not have a high risk of COVID. The decision-making group needs to make its decisions based on local and/or regional data.

The group should give consideration to the implications of tikanga and mātauranga Māori, ideally including involving tikanga experts in the

Comments

! Or personal protective equipment

Commented

agree with considering implications of tikanga is important, though I would note that identifying tikanga experts to participate in such a group at short notice (within hours or days) will often be unrealistic. In a pandemic setting, prioritisation decisions may need to be made by an individual clinical service or a small health provider/practice, at very short notice indeed.

discussion, when making decisions about standards of care in times of crisis.

Should the standard of care for patients change in an epidemic?

Patients should receive the best available care during a pandemic. However, the range of options for what is 'best' could well change as a result of the constraints imposed by a pandemic. For example, patients may not be allowed to have visitors (especially when PPE is scarce). This will be necessary to protect staff and other patients and reduce the risk of transmission from and to visitors.

This could mean that some patients become seriously ill and die without the usual support of relatives and friends. This will inevitably cause distress to all parties. Access to other modes of communication, such as phone and video calls, should be provided where possible. It is important that all organisations inform the public about any changes to standards of care before such changes are introduced (University of Sydney 2020).

Where patients who are not infected are discharged earlier because of the concerns of a pandemic, those patients should receive more extensive continuing care at home to ensure they are not disadvantaged (University of Sydney 2020). This could be achieved through increased telehealth services, and should only occur when clinically appropriate.

How will data be collected and shared?

Data sharing between different institutions is critical in effective resource allocation. For example, there may be opportunities for district health boards (DHBs) to share resources, depending on the extent of impact of COVID-19 in each region. It will be important to ensure that adequate care standards are in place to protect privacy and maintain confidential communications – crisis standards of care do not weaken the fundamental obligation to protect the privacy and confidentiality of patients.

Collecting high-quality ethnicity and disability data for monitoring is fundamentally important. Data collection and sharing enables the response measures and allocation decisions to be monitored and tailored to respond promptly and effectively to evidence of inequitable impacts and outcomes.

What are organisations' obligations?

Organisations must share information, adjust protocols, and balance resources and patient loads across their immediate surrounding region to ensure as consistent a standard of care is maintained as possible. Public health decisions should be transparent.

Commented

I do not think this section adequately recognises that for many treatments, the risk of pandemic virus infection, or the risk of being unable to manage severe adverse events during a pandemic, may change the risk/benefit of a therapy that would be 'standard of care' in normal times. Examples are certain cancer therapies, especially if not clinically urgent, where the risk of severe immunosuppression or complications during a pandemic may require that treatment is deferred, or alternative treatments provided. This is discussed in recently-published interim consensus Australasian guidance: doi: 10.5694/mja2.50607

Commented

This is completely unrealistic and inappropriate. Every department in every clinical centre will have to alter its services at very short notice if we face a severe pandemic change, and it is not appropriate to consult the public before making such changes. Instead, "Organisations should be transparent with patients and staff about changes to standard of care, and should seek to review and, where appropriate, to reverse, these changes once the pandemic crisis allows".

Commented

I recommend change this to, "to minimise disadvantage". In a severe pandemic outbreak, such as that in Northern Italy, or London earlier this year, some disadvantage is completely unavoidable.

Example 1: Intensive care unit allocation

Introduction

In order to show fairness and sustain public trust, we need to implement triage guidelines consistently throughout New Zealand. Solidarity requires that resource allocation reflect our common interest in addressing any pandemic; collaborative regional cooperation may require the reallocation of resources between health services based on differential need. Clear and consistent triage guidelines and triage committees can reduce the moral injury and distress frontline health workers can experience during a pandemic.

Current approaches of 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 classes, Maori, Pacific peoples and people with disability.

There are several tensions to be considered when allocating resources in the clinical setting, as there is the additional consideration of clinical

appropriateness to take into account, which may limit the ability for equity to be fully realised.

Applying the principles

Prioritising the people most in need

Patients with the most severe disease who are most likely to die or suffer without treatment should be prioritised for ICU access. Often this principle will align with getting the most out of resources because the sickest patients will be most likely to benefit from ICU care. However, some patients will fall below a threshold where they are so sick there is minimal chance of their survival, even with ICU intervention.

Getting the most out of resources

Most critical care triage guidelines prioritise saving lives as the primary ethical value, for example, resources should be allocated to patients with the greatest capacity to benefit from ICU. This is often defined as the likelihood of surviving an ICU admission and for one year following discharge (Bideson 2018). This principle conflicts with the principle of achieving equity of clinical outcomes.

Giving priority to individuals who have the most chance of benefiting from treatment in ICU may achieve the aim of saving the maximum number of lives. But greater ability to benefit is often associated with wider

determinants of health, such as higher socioeconomic status. Socioeconomic status in turn may be systematically distributed to some groups and away from others. As a result, a socioeconomically advantaged group may be more likely to be represented among those individuals selected for ICU. Where reduced ability to benefit by reason of socioeconomic disadvantage is linked to injustice, this results in a tension with the value of equity.

Achieving equity

Given the unequal distribution of comorbidity and multi-morbidity amongst the New Zealand population (for example on the grounds of socioeconomic deprivation and ethnicity), it will be very difficult to avoid unequal outcomes based on demographic factors.

For critically ill COVID-19 patients, the primary consideration should be whether ICU care is in the patient's best interest and what other care may be appropriate, including palliative or supportive care. When ICU space is severely limited, there will be tension between utility (saving the most lives) and equity (ensuring fair outcomes between groups). This tension cannot be resolved via ethical analysis at the stage of admission to ICU, as clinical considerations take precedent at that stage.

All people are equally deserving of care

Disability status or age must not be used as a simple proxy for health status or capacity to benefit. Screening measures, including the quality-adjusted life year (QALY) measure, must be avoided as they are inherently biased against people with disabilities. Triage decisions should be based on assessment of an individual's personal medical history (noting the tendency for medical records to be error-prone).

General considerations

The following considerations have been adapted from Maves et al 2020.

When implemented, triage guidelines must be applied to all current and new patients presenting with critical illness, regardless of the diagnosis of COVID-19 or other illness.

NEAC recommends an independent decision-making group be established to enact a triage plan.

It is important to ensure that patients who do not initially receive critical care resources are still provided with the best supportive care possible and are re-evaluated regularly for consideration of resource allocation as supplies become available.

Patients who are unable to receive invasive mechanical ventilation may be able to receive supplemental oxygen through a non-invasive route as resources permit.

The implementation of early palliative care interventions can provide a better quality of life, less treatment intensity, and no consistent impact on mortality (Maves et al 2020). This offers a strong rationale for carefully integrating symptom management alongside palliative care principles for all patients who are impacted by crisis care.

There is no ethically significant difference between withholding and withdrawing life-sustaining treatment; but health care providers, patients and families often find decisions to withdraw treatment more emotionally and psychologically challenging.

Time trials of ICU may be necessary to manage patients and families' expectations and avoiding prolonged stays in ICU with minimal and decreasing prospects of benefit. Clear criteria and schedules for re-assessing patients on time trials will be necessary.

ICU care may be ethically withdrawn when it is no longer in the patient's best interests (harm of treatment now outweighs the prospect of any benefit). Decisions about the patients' best interests must follow the

process and principles of right 7(4) in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.⁷ Care may also be ethically withdrawn if it is judged to be medically inappropriate because the prospect of benefit falls below a predetermined threshold.

Depending on the demand for care within ICU, estimated length of stay per patient and epidemiological surge projections, hospitals may be justified in keeping some ICU beds empty in order to be prepared to care for subsequent high-priority patients.

Health care should not be denied or limited based on quality of life judgements (Maves et al 2020).

⁷ See www.hdc.org.nz/your-requests/about-the-code/section-7-the-health-and-disability-services-consumers-right.

Table 3: Assessment of the impact of mechanisms suggested in literature to prioritise scarce resources against the resource allocation principles

Mechanisms	All people are equally deserving of care	Getting the most from the resources (population health)	Achieving equity (achieve more equal outcomes)	Prioritising the people most in need
Clinical scoring + prognosis (eg, SOFA score, clinical frailty, co-morbidities)	Assesses all patients by the same standard and therefore ensures consistency. Need to ensure that disability status and age are not used as proxies for capacity to benefit and that QALY assessments are excluded.	Will successfully maximise the most efficient use of resources to minimise population mortality and morbidity.	Will not achieve equitable outcomes between groups because of the unequal distribution of health status amongst the population, including disparities according to ethnicity, disability and socioeconomic status.	In many cases, will result in high priority for the sickest patients; but will exclude the very sickest patients who fall below a threshold where there is minimal chance of survival to ICU discharge (or one year after discharge).
Randomisation / lottery	Gives everyone an equal chance.	Does not ensure the efficient use of resources to maximise benefit.	Should achieve relatively equitable outcomes between patients/groups, at least amongst those who have access to health care and present for triage assessment.	Does not prioritise those with the most need.

Mechanisms	All people are equally deserving of care	Getting the most from the resources (population health)	Achieving equity (achieve 'more equal outcomes')	Prioritising the people most in need
Priority for health care and frontline workers (eg. cleaners)	Does not treat all patients equally because it gives priority to some classes of patients based on their employment status and perceived social utility.	Supports population health if: (1) priority access to treatment acts as an incentive for essential frontline workers to continue to work before infection and/or (2) means essential frontline workers recover from critical infection and can resume work. (These assumptions would need to be tested with empirical evidence.)	May support equitable outcomes if we believe that primary health care and frontline workers are fairly entitled to priority access due to the special burdens they have carried on behalf of society.	May prioritise those in greatest need if we interpreted need as those at greatest risk of harm: evidence suggests that health workers and, in some case, frontline workers are at significantly increased risk of contracting a pandemic infection, such as COVID-19.

Example 2: Personal protective equipment allocation

Introduction

COVID-19 is an easily transmissible infectious disease. Personal protective equipment (PPE) is an important component, but only one part, of a system protecting staff and other patients from cross-infection of easily transmissible infectious diseases and can be considered a harm reduction resource since appropriate use significantly reduces risk of viral transmission.

During a pandemic, PPE must be prioritised and allocated based on proportionate and reasoned guidelines. Overuse of PPE is a form of misuse and should be avoided.

Applying the principles

Prioritising the people most in need

Because the principle getting the most from the resources in this case is defined in terms of harm minimisation, this will for the most part align with prioritising the people most in need. For both principles, we should prioritise those at greatest risk (both of infection and risk of severe COVID-19 mortality).

'Need' can relate to several distinct criteria. In the case of PPE, these include: the need to reduce the chance of contracting infection by those who take greater risks because of their health care or other roles; the need to protect those who are most likely to contract COVID-19 through contact with carers; the need to preserve the welfare of those who are most affected by COVID-19 (eg, those who are dying and their families).

Another option is to prioritise populations that are particularly impacted by COVID-19.

Getting the most from the resources

Distribution of PPE should minimise infection rates of COVID-19 (and other pathogens) in order to reduce mortality and morbidity from COVID-19 (and other diseases) across the population.

This takes account of the risk of exposure and the risk of infection resulting in severe COVID-19 morbidity or mortality. Some groups may be at high risk of exposure but low risk of severe COVID-19 or vice versa.

Risk of harm to providers contracting COVID-19 within the health care system will vary according to:

- the nature of the clinical encounter, that is, intubation is more dangerous than transporting patients
- the infectious status of the patient, that is, the patient has confirmed, suspected or does not have COVID-19
- other patient characteristics, for example, they are agitated or violent
- other health provider characteristics, for example, comorbidities or age.

When distributing limited PPE to clinicians during a pandemic, an egalitarian approach that treats all clinical roles as equal may not serve the principle of getting the most from the resources.

'Social worth' is an interpretation of this principle that may be ethically justified in the unique setting of a pandemic.

This recommendation arose from the recognition that some members of society are critical to a successful response to a pandemic.

Applied to PPE, social worth would require assessment not of how many lives a clinician could save, but of the instrumental value of that clinician in providing patient care, both during and after the pandemic.

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.

Achieving equity

Equity requires that distribution of PPE be prioritised to protect marginalised groups and prevent or improve inequality around the risk of contracting COVID-19 or of suffering from a severe COVID-19 infection. This can be achieved by recognising epistemic authority, that is, listening to marginalised groups regarding what they need and how best to distribute resources – they have valuable and specialist knowledge about their own needs.

Examples include working with iwi and Māori health groups to ensure the needs of Māori are met and Māori are involved in or control distribution within their communities.

Similarly, it is important to work with consumer and interest groups, for example the Disabled Persons Assembly NZ (DPA), to ensure disabled people are not left behind.

Equity may also require additional provision of PPE to Māori health providers and PPE provision to groups in which Māori and Pacific peoples are more highly represented, for example care home workers.

All people are equally deserving of care

Seniority within the health system or organisational hierarchy is irrelevant to PPE distribution. The only exception would be staff with critical expertise whose absence would disproportionately impact the system's ability to provide adequate treatment. Where this justification is used, the reasoning must be transparent.

PPE should not be diverted from standard clinical use in the treatment of other diseases or conditions (eg. surgery); expect when the risk of exposure and harm from COVID-19 exceeds the risks related to those other applications.

General considerations

The following considerations have been adapted from Bean et al 2020.

If staff are not provided with adequate PPE, their ethical and legal obligations to work in such environments may be weakened (Schuldenik 2020).

Staff have an ethical obligation, based on their obligation to patients and colleagues, to contribute to a safe working environment. This includes the obligation to raise concerns about inadequate PPE. Managers must ensure clear and safe communication channels are available. Staff should not be censured or reprimanded for raising reasonable concerns about PPE supply.

Organisations should implement clear decision-making plans, with regular communication and centralised and coordinated distribution.

As with vaccines, prioritisation of health care workers can be justified on several grounds: because of their increased risk (protect the vulnerable) and their instrumental role in maintaining essential social services (best use of resources) and in recognition of the greater burdens they are carrying on behalf of society before the development of any vaccine (reciprocity).

In order to optimise PPE availability, health systems must coordinate and cooperate to minimise the need for PPE, coordinate supply chain and distribution, and use PPE effectively and appropriately.³ This is supported by the ethical value of solidarity.

³ For specific guidance, see WHO 2020

Ensuring effective use of PPE requires appropriate training in infection prevention and control (IPC) to be rolled out in conjunction with PPE.

In order to conserve PPE, visitors should be restricted. Equity requires that exceptions be made for minors or disabled patients who need access to careers and, in some cases, for patients at the end of life. Where visitors are permitted, they should be provided with clear instructions about how to put on and remove PPE and about performing hand hygiene before putting on and after removing PPE. The instructions should be provided under the supervision of a dedicated health care worker.

Telehealth services can also help conserve PPE.

As described above, cancelling non-urgent or elective procedures that require use of PPE can assist in responding to pandemic outbreaks. However, such restrictions should be continually reassessed.

Example 3: Vaccine allocation

Introduction

Safe and effective vaccines are the straightest route to controlling the COVID-19 pandemic. When a vaccine is developed, demand will likely exceed immediate supply and decisions regarding prioritisation will be necessary.

In the case of the COVID-19 pandemic, as there is currently no approved vaccine, this section comments on general ethical principles and priorities for a COVID-19 immunisation programme.

Such a programme must be driven by the science of the vaccine, including vaccine efficacy using both the recommended full schedule and less than the full schedule, course of vaccine administration, contraindication and vaccine safety considerations, vaccine presentation (eg, multi-dose presentation), cost of the vaccine and vaccine supply (whether sufficient quantities can be purchased or produced locally). Immunisation must be based on sound infection control principles developed from the best available immunological, epidemiological and clinical evidence. Pharmacovigilance and surveillance to monitor for

adverse events and effectiveness will be especially important given the anticipated lack of long-term safety and efficacy data.

Applying the principles

Getting the most from the resources

An immunisation programme should aim to maximise the benefit of a vaccine in reducing national mortality and morbidity as a result of COVID-19 and enable the functioning of essential social services.

Prioritising the people most in need

Vaccine allocation could also prioritise people who are the most vulnerable to contracting COVID-19 and/or developing severe COVID-19 disease. Vulnerability depends on both biological and social features.

Priority may be given to individuals with inadequate or limited capacity to respond to the COVID-19 using non-pharmacological public health measures (eg, social distancing, PPE).

Priority may be given to individuals whose work is essential for maintaining health care systems and pandemic response and essential social services.

In relation to vaccination, protecting the most vulnerable and those at highest risk typically aligns with the principle of maximising the population benefit of vaccines.¹

Some people with underlying health conditions or pre-existing co-morbidities will be vulnerable to developing severe or critical COVID-19 infection and at increased risk of dying or suffering serious and possible long term COVID-19 related morbidity.

Other people will be vulnerable because of their social situation or role, including frontline health workers at high risk exposure to COVID-19 patients and people with less capacity to socially isolate (eg, prisoners or those in residential care facilities).

Achieving equity

Vaccine allocation should avoid remediable differences among groups of people based on social, economic, demographic or geographic factors. An equitable immunisation programme will require:

- recognition of epistemic authority (Vulnerable and marginalised communities have valuable understandings of their own needs)
- allocation of resources to protect and promote the interests of vulnerable or marginalised populations
- funding for equitable access to vaccines, including funding for programmes for Māori to design and deliver vaccine programmes to

their own communities. Affordability and access must not become barriers to widespread vaccine availability.

Vaccine allocation should try to avoid or minimise compounding disadvantage by ensuring those who are not prioritised for access to vaccines receive other essential resources, such as PPE or priority access to health care

All people are equally deserving of care

All individuals' interests should count equally, and all people should be assessed against the same criteria for access to a vaccine.

From an epidemiological perspective, all individuals living in a geographic area (such as New Zealand) must be considered as part of the immunisation programme, regardless of their immigration status. This includes all non-residents currently living in, or unable to leave, New Zealand

General considerations

Vaccines are beneficial to individuals and populations.

Efforts to control the COVID-19 pandemic at the national level will only succeed with a coordinated regional and global strategy. New Zealand should participate in and support international conversations about fair vaccine allocation globally.

Commented : I do not necessarily agree – this statement should be checked with a vaccine or ID specialist. It is very plausible that some vulnerable individuals (e.g. the very elderly, people with cancer or receiving immunosuppressive therapies) will derive the LEAST benefit from vaccination, because their immunosuppressed status or older age may prevent them from generating a protective vaccine response, and because (unlike those without such risk factors), they come into contact with fewer other people. Therefore, it is possible that, for vulnerable individuals, the best means of protection is to prioritise the vaccination of younger, non-immunocompromised (i.e. non-vulnerable) individuals (the ‘arm being’ herd immunity), or the vaccination of their family members or carers (with the goal of ‘cocooning’).

Vaccination must be voluntary unless mandatory vaccination becomes essential to avoid concrete and serious harm. Efforts to maximise efficient use of resources and save lives may conflict with individual autonomy. Given the enormous economic and social impact of the COVID-19 pandemic and unrepresented restrictions on personal liberty, mandatory or incentivised vaccination may be considered for COVID-19. For example, vaccination may be considered a requirement for health providers given their potential role as vectors. The core public health principles of necessity and least infringement require that any restriction on individual liberty must be necessary to achieve the public health goal.

Randomisation or lotteries can help determine distribution of vaccines between individuals or groups that could reasonably be expected to derive equal benefit from the vaccine. Randomisation gives each person an equal chance to benefit. A 'first-come-first-served' approach should be avoided because it prioritises those with greater access to health services, information and/or wealth.

Prioritisation of specific groups for access to a vaccine will require careful public justification and communication to ensure that these groups do not perceive themselves as test subjects or that others perceive them as being unfairly privileged.

Several principles can support specific distribution mechanisms. For example, prioritising health frontline workers can be justified by their

greater risk (protect the vulnerable) and their instrumental role in maintaining essential social services (best use of resources), as well as in recognition of the greater burdens they carried on behalf of society before an effective vaccine was developed (reciprocity).

Commented
"unprecedented"?

Should this read.



**The Royal Australian
and New Zealand
College of Obstetricians
and Gynaecologists**

Excellence in Women's Health

1 July 2020

National Ethics Advisory Committee
neac@moh.govt.nz

Draft Ethical Framework for Resource Allocation in Times of Scarcity

Thank you for the opportunity to provide a submission on the Draft Ethical Framework for Resource Allocation in Times of Scarcity.

About the Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is a not-for-profit organisation dedicated to the establishment of high standards of practice in obstetrics and gynaecology and 'excellence in women's health'. The College trains and accredits doctors throughout Australia and New Zealand in the specialties of obstetrics and gynaecology. The College also supports research into women's health and advocates for women's healthcare by forging productive relationships with individuals, the community, professional organisations and government.

In New Zealand RANZCOG's Te Kāhui Oranga ō Nuku supports College activities, taking into account the context of the New Zealand health system and the needs of women in Aotearoa New Zealand. A particular focus of Te Kāhui Oranga ō Nuku, and its sub-committee He Hono Wāhine, is recognising Māori as tangata whenua and supporting initiatives that will improve equity of outcomes.

Feedback on the proposed reclassification of the HPV vaccine

We note that this framework is for obvious reasons focused specifically on COVID-19 and the implications this has on ethical decision making in relation to constrained resources. We agree that the principles contained in the final document should be applicable to decision making more broadly.

1. Does the Framework captures the ethical tensions in resource allocation in times of scarcity.

We are supportive of the four ethical principles outlined in the document: All people are equally deserving of care; Getting the most from the resources; Prioritising the people most in need; Achieving Equity. We also agree that it is imperative that these are considered in a way that takes account of our obligations under Te Tiriti o Waitangi: The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery and monitoring of primary health care; The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services; The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori; and the principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of primary health services.

Additionally, however, we believe it should be explicitly stated that these principles and rights sit alongside the consumer rights as outlined in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

We agree that the document illustrates that each of the principles and rights exist and have validity, but tensions exist between the principles when faced with a specific type of resource decision. As it stands responsibility to make the decisions sits with healthcare providers and their appointed decision making body. The proposal for each institution to have a high level decision making group to guide overall clinical decision making, thus separating decisions on individual care from the overall resource constraining decision is helpful and wise. The knowledge, skills, and experience of these groups is likely to vary between groups.

Additionally, there will be aspect of this decision making that can only be made with detailed understanding of the clinical circumstances. Our experience to date, supporting obstetricians and gynaecologists facing difficult rationing decisions, clearly demonstrated a desire to actively engage in decision making and yet find this challenging without tools to help the process. While reference is made in Table 3 to some of the tools which may be used to help decision makers in applying the four ethical principles, there is no commentary on this in the body of the document. We feel it would be helpful to provide more guidance with respect to tools that would enable the practical application of the principles. This could be as an appendix or an additional guidance document referenced in this document.

2. Does the Framework helps decision-makers understand the ethical implications of making decisions.
We feel the document overall does a good job helping decision-makers aware of the ethical implications of decision making. The examples are very helpful and demonstrate how the four principles might be applied and the tensions between them.

3. Whether the Framework helps decision-makers consider equity when responding to COVID-19.

The document explicitly states that achieving equity is one of the four ethical principles. It further states that utility (saving the most lives) and equity (ensuring fair outcomes between groups) are in tension, particularly in the context of a COVID-19 pandemic, where many of the markers of risk for a poorer outcome from infection are also markers of social inequity. We agree that ethical considerations are unable to resolve the tensions or deliver equitable outcomes in those patients who become critically unwell with the infection. The example looking at distribution of PPE and ensuring decision making supports equity of access and outcome is helpful. While it may be that the actions required to enable this kind of decision making need to occur locally, considering the specific needs of that population, some more detailed guidance gathered from marginalised groups regarding what they need and how best to distribute resources would be a useful addition. As would, some specific input from iwi and Māori health groups to guide the application of this process to the needs of Māori.

4. Feedback on the Te Tiriti Principles and their application to resource allocation decisions.

We note that the membership of the NEAC group responsible for the production of the document had strong Māori representation.

Te Tiriti Principles and the four ethical principles are in tension but we agree that both highlight important factors that must be considered for Māori when allocating scarce resources.

What is lacking is a more integrated approach that looks specifically at how Te Tiriti Principles are actively applied at a high level. The examples were helpful in this regard and illustrated well that the way they are applied will vary depending on the resource being considered. Development of a worksheet, tools to use, and or questions to consider in relation to local decision making would strengthen the guidance.

The NEAC 2007 document Guidance on Pandemic Ethics provides some useful questions which could be reviewed and expanded on and aligned to newly proposed framework:

1. Would this patient meet the clinical criteria for this treatment during normal times? (That is, when there is not overwhelming demand for the resource.)
2. Is this treatment the most beneficial form of treatment for this patient?
3. Does this patient require this treatment immediately? (That is, it is not possible for this patient's treatment to be safely deferred.)
4. Could capacity to deliver this service be expanded to treat this patient, with only minimal disadvantage to others?
5. Is it impossible to mitigate the negative effects for this patient of missing out on this treatment?
6. Can this patient be ranked highly enough based on benefit from this treatment?
7. Can this patient be ranked highly enough based on order of presentation?
8. Can this patient be ranked highly enough based on random selection?

5. Further comments and suggested changes for NEAC to consider for the final draft.

As already mentioned this is a well-considered and much needed ethical framework to guide difficult decisions around resources during the COVID-19 crisis. Consideration needs to be given to more detailed guidance for local decision makers, particularly those clinical leaders who do not have the experience or training to draw on when forced to make these difficult decisions. These tools need not be part of this document but may be referenced in it, possibly in an update of Getting Through Together.

6. What ethical issues or areas of work you think should be covered in a substantial review of Getting Through Together.

As already mentioned above it would be helpful to have some practical tools to use that are both general and focused on specific types of decision making.

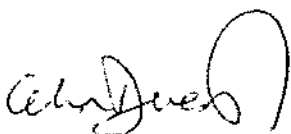
The COVID-19 pandemic has already exposed some particular challenges for the delivery of women's health services such as:

- access to contraception
- access to abortion services
- providing an environment for birthing women that enables them to feel safe and supported
- providing time sensitive pregnancy ultrasound examinations

We would value an opportunity to provide input to the development of guidance specific to these and other issues specific to our specialty.

If you need further information on any of the comments above please contact me through:

Ngā mihi



Chair, Te Kāhui Oranga ō Nuku

Response ID ANON-F5GY-YFXH-T

Submitted to Consultation on the Draft Ethical Framework for Resource Allocation In Times of Scarcity
Submitted on 2020-07-08 10:48:53

Your details

What is your name?

Name:

Contact details

Email:

policy@alzheimers.org.nz

What is your organisation?

Organisation:

Alzheimers New Zealand

What is your role?

Please enter your role here:

Policy Advisor

Which interest group do you best represent?

Consumer

Use this text box if you selected 'Other':

Feedback on the Framework

The Framework captures the ethical tensions in resource allocation in times of scarcity

Agree

Please outline your reasons.:

The draft framework acknowledges the tensions that exist when allocating resources at these times and acknowledges that good decision-making involves recognising rather than ignoring the tensions. However, issues are described rather than addressed resulting in a paucity of advice. So - while the document captures the tensions, merely capturing the tensions is not enough to be helpful.

The Framework helps decision-makers understand the ethical implications of making decisions

Disagree

Please outline your reasons.:

That "pandemic planning decisions should be very clearly underpinned by ethical values" seems obvious. Unfortunately, there is little guidance offered as to how this could be managed, what the options for consideration should be, and how to "weigh" the consequences. In pandemic planning decision making, decisions must be made quickly. There is no guidance for decision-makers to understand the ethical implications of their decisions. People in decision-making roles rely on guidance. Well informed and clear guidelines are essential. Again - while it points the way to contradictory ethical values - it is not enough to just understand the ethical values.

The Framework helps decision-makers consider equity when responding to COVID-19

Disagree

Please outline your reasons.:

The Framework is clear that equity is important. The paper also acknowledges that "it is likely to be difficult to ameliorate existing inequality during a public health crisis" (p7). Later it recommends that equity is at the forefront of decision-making, but we are given no direction on how this is to work in practice. Guidance around this issue is vital, and such guidance is particularly relevant for people living with dementia. The level of stigma in the community and poor understanding of dementia among health professionals results in unfair treatment of those with a dementia diagnosis. The degree of misunderstanding and neglect throughout the community with or without Covid 19 merely underlines how much a better approach to dementia is needed. Given the existence of widespread stigma around older age, dementia, and disability, it would be good to see concrete measures that would be adopted in emergency "bedside" decision making to limit their inadvertent influence.

NEAC seek feedback on the Te Tiriti Principles and their application to resource allocation decisions

Please provide feedback:

It is well known previous pandemics have had a disproportionately negative impact on Māori. Therefore, the NEAC Framework must be able to deliver equitable outcomes for Māori peoples. Reminding readers of Te Tiriti of Waitangi obligations is useful to the extent it helps deliver equitable outcomes. Unfortunately, the Framework ends up with a circular approach. It signals that Treaty principles need to be taken into account, and then delegates ethical decision making to groups at the national and local level who should "take into account Te Tiriti articles and principles and their application to resource allocation". What priority this is to have amongst other issues to be considered is uncertain and contingent on other factors. For example, when considering resource allocation, "Māori tikanga and mātauranga Māori may need to be considered in the context of challenging other values not just sitting alongside those values" (p.12).

Please provide any further comments, feedback or proposed changes for NEAC to consider when finalising the Framework**Feedback::**

Relying on the myriad of separate health bodies to develop their own guidelines could lead to further inequities, inconsistencies, and loss of public trust. In a country of 5 million we think there is an opportunity for national guidance on this. NEAC's own expertise in this space makes it ideally placed to take up that role and develop national policies and protocols to guide institutional decision making in a quick and efficient manner. Alongside the above we agree with the benefits of the decision-making group basing its decisions on local and or regional data to avoid national decisions around consistency causing local harm. Consistency around triage guidelines (p15) supports the need for national guidelines rather than local/regional guidelines.

Broader Pandemic Ethics - Your Views**What area(s) of pandemic ethics should NEAC take into account during the review of Getting Through Together?**

In the context of pandemics, what ethical guidance do you think would be beneficial for decision-makers, communities and individuals?:

We acknowledge it is very difficult. The problem the dementia community faces is that people are dismissed just because they have a dementia diagnosis - so we come up against a wall of discrimination and stigma. Therefore, that is why we favour a human rights approach:

After diagnosis, people with dementia can live many years of meaningful existence with a high quality of life. A diagnosis of dementia on its own should therefore never be a reason to refuse people access to treatment, care and support.

Although there are many challenges, Governments and healthcare systems should take all necessary measures to ensure that the needed infrastructure (in addition to sufficient human resources) is in place so as to minimise the need for triage decisions. Aotearoa New Zealand still has no dementia action plan in place - in contravention of our international obligations.

Everyone, irrespective of whether they do or do not receive intensive care services, should be treated with compassion and respect for their dignity, as well as their customs, spiritual beliefs and religion, and given, when appropriate, pain relief, sedation and/or palliative care.

Publishing submissions and privacy**Publishing submissions**

You may publish this submission

Official Information Act responses

Remove my personal details from responses to Official Information Act requests

Commercially sensitive information

This submission does not contain commercially sensitive information

If your submission contains commercially sensitive information, please let us know where.:



New Zealand
College of Midwives

TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

8th July 2020

Draft Ethical Framework for Resource Allocation in Times of Scarcity - National Ethics Advisory Committee

New Zealand College of Midwives

PO Box 21 206

Christchurch 8143

Tel (03) 377 2732

The New Zealand College of Midwives is the professional organisation for midwifery. Our members are employed and self-employed and collectively represent over 90% of the practising midwives in this country. There are approximately 3,000 midwives who hold an Annual Practising Certificate (APC). These midwives provide maternity care to, on average, 60,000 women and babies each year. New Zealand has a unique and efficient maternity service model which centres care around the needs of the woman and her baby.

Midwives undertake a four-year equivalent undergraduate degree to become registered followed by a first year of practice program that includes full mentoring by senior midwives. The undergraduate curriculum meets all international regulatory and education standards. Midwives are authorised prescribers in relation to their Scope of Practice as determined by the Midwifery Council.

Midwives provide an accessible and primary health care service for women in the community within a continuity of carer model as Lead Maternity Carers. Midwives can also choose to work within secondary and tertiary maternity facilities, providing essential care to women with complex maternity needs.

The College offers information, education and advice to women, midwives, district health boards, health and social service agencies and the Ministry of Health regarding midwifery and maternity issues. Midwives interface with a multitude of other health professionals and agencies to support women to achieve the optimum outcome for their pregnancies, health and wellbeing



New Zealand
College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

8th July 2020

National Ethics Advisory Committee

neac@moh.govt.nz

Draft Ethical Framework for Resource Allocation in Times of Scarcity - National Ethics Advisory Committee

The New Zealand College of Midwives (the College) welcomes the opportunity to provide feedback on the Draft Ethical Framework for Resource Allocation in Times of Scarcity. The College supports the development of a guidance document outlining clearly the ethical principles to be considered when responding to the COVID-19 pandemic. The ethical framework needs to be informed by what we already know about the challenges we face in Aotearoa New Zealand, in regards to equity, racism, and the gaps in health and support services.

The College has a professional focus on midwifery, midwives and their wellbeing, and the wellbeing of pregnant, birthing and postnatal woman and their whānau. The COVID-19 pandemic response should provide an impetus for planning and action within maternity, public health and mental health services that go way beyond the usual ways of working.

Midwives, in Aotearoa New Zealand, work in partnership with women to provide the necessary skilled support, care and advice during pregnancy, birth, labour, and the post-birth period. Partnership is a key concept for the midwifery profession and midwives engage with women and their families in relationships of trust, shared decision making and responsibility, negotiation and shared understanding. Midwifery has a role in public health and is both a preventative and acute response front-line health service which impacts positively on maternal, infant and child wellbeing, both short and long-term. Midwives played a key essential role during the COVID-19 lock down period and continued to provide pregnancy, labour, birth and postnatal services.

With the College focus in mind here is our feedback on the Draft Ethical Framework for Resource Allocation in Times of Scarcity.



Executive summary

- Addressing issues of racism, inequity and poverty (structural violence) will be critical to the success of any future pandemic plan, including resource allocation work.
- It is important to make it clear that populations are only marginalised and often named vulnerable because services have not been adequately set up to meet their needs.
- Midwifery representatives need to be included in each decision-making group at both national and local levels.
- Telehealth is rarely a realistic option for midwifery care, and recognition of the in-person, continuity of care that midwives continue to provide during pandemic situations is necessary.
- Access to appropriate PPE is an issue that has been raised in many other sectors. For midwives the lack of access to PPE increased the stressors in a very difficult environment. An improved pathway to supporting access to PPE is critical for any future pandemic response.
- Midwives, as a designated essential workforce, should be included in those workers deemed to be “in need” (“those who take greater risks because of their health care or other roles”), when decisions concerning prioritisation for distribution of harm reduction resources such as PPE are made.
- Communities who have been marginalised and who suffer poor health and social outcomes due to inequity should be involved in all planning and decision making about what resources are needed and how these resources should be distributed.

Feedback

1.0 The College strongly agrees with the statement about Te Tiriti o Waitangi (p. 2), and the need to honour the Governments’ obligations to equal partnership and the acknowledgment of Māori rights and interests. Addressing issues of racism, inequity and poverty now will be critical to the success of any future pandemic plan. Racial and ethnic inequities contribute to poor health outcomes. Discrimination and its effects on health and wellbeing, and exposure to racial discrimination are associated with poorer self-rated health, poorer mental health and greater life dissatisfaction.¹ Any plans for pandemic recovery or pandemic preparedness will need to take these issues into account.

¹ Cormack, D., Stanley, J., & Harris, R. (2018). Multiple forms of discrimination and relationships with health and wellbeing: findings from national cross-sectional surveys in Aotearoa/New Zealand. *International Journal for Equity in Health*, 17(26). <https://equityhealth.biomedcentral.com/articles/10.1186/s12939-018-0735-y>



We support the key recommendations of the Human Rights Commission which includes Te Tiriti based partnership across the Government's COVID-19 response ²

- 2.0 A shift to an approach based on a transformative concept of cultural safety, which involves a critique of power imbalances is necessary to improve health inequities as part of any planning for future public health emergencies or pandemics. If evidence of cultural safety became a requirement for accreditation of all health services likely to be involved in a pandemic response this may support the transformative shift which is necessary. The College supports services and programmes for Māori, created, developed and delivered by Māori.
- 3.0 The College is in agreement with the 'focus on equity' section of the document (p.3) which recognises the impact of pandemics and public health emergencies on marginalised communities and the need for equity to be considered during the allocation of resources to achieve equitable outcomes. The College also agrees with a statement made by child advocate Melton in 1987 about the welfare of children, "Attention to the welfare of children is a cornerstone of a society respectful of human rights."³ Attention to the welfare of children cannot exist in isolation from attention to the welfare of pregnant, birthing and postnatal women. During the COVID-19 levels 4 and 3, in particular, midwives played a central role in providing information and support to women and whānau and we consider this support for mothering and parenting is critically important. Because of this we would like to see support for the needs of women, babies and children stated in the ethical framework.
- 4.0 The College considers that the term marginalised communities may need more attention within the ethical framework. It is important to make it clear that populations are only marginalised and often named vulnerable because services have not been set up to meet their needs. The health and wellbeing needs of refugee, migrant and asylum seeker populations in Aotearoa New Zealand are not always recognised. As Aotearoa New Zealand is about to increase the refugee quota from 1,000 to 1,500 people per year, effective from July 2020, and is also expanding the resettlement locations, we feel that the needs of these populations should be part of the discussion.

² Human Rights Commission. (2020). *Human Rights and Te Tiriti o Waitangi: COVID-19 and Alert Level 4 in Aotearoa New Zealand. Mōtika Tangata mē Te Tiriti o Waitangi: Mate Korona mē te Noho Rāhui i Aotearoa Taumata 4*. Wellington, HRC.

³ Melton, G. (1987). Children, Politics and Morality: The Ethics of Child Advocacy. *Journal of Clinical Child Psychology*, 16(4):357-367.



- 5.0 Poverty, racism, gender inequality and other social determinants of disease are described as structural violence by DeBruin et al. (2012)⁴ and to counter the social injustice of these structural inequalities health disparities and access barriers (such as geographical and socioeconomic) need to be addressed alongside resource allocation and equity of access. DeBruin et al. recommend collaboration with local providers to enhance understanding of the needs of communities.
- 6.0 In terms of the ethical principles in the document (p. 5) the College agrees that it is necessary to recognise the tensions between values and principles. The College supports a feminist ethics approach, which is viewed more as a way of “doing ethics’ than as a branch of ethics.⁵ The feminist approach takes into account inequalities, shared resources, and partnership models, along with a focus on context and an awareness of discrimination, oppression, domination and power politics.
- 7.0 The section on allocation of resources puts personal protective equipment (PPE) under the heading of public health resources rather than clinical resources (p. 11). PPE is also a clinical resource.
- 8.0 The College agrees with the recommendation for the establishment of a decision-making group at national and local levels (p. 12) and we consider that midwifery representatives need to be included in each group as they are essential front-line workers.
- 9.0 In regards to the whether the standard of care should change in an epidemic (p. 14), the College notes that increased telehealth services are suggested as support for ‘non-infected’ patients who are discharged earlier. For recently birthed women going home early from maternity facilities with their babies, telehealth is rarely an option for midwifery care and we would welcome recognition of the in-person care that midwives provide during pandemic situations. Maternity services were considered an essential health service, so midwives continued to work and deal with the same volumes of women needing care throughout the pandemic response.
10. 0 There was a lack of structural support for community midwives (LMCs) and because of this the College and the Midwifery and Maternity Provider Organisation (MMPO) had to step in and provide the necessary support. This had a resource impact for both organisations. In terms of the section on

⁴ DeBruin, D., Liaschenko, J., & Marshall, M. F. (2012). Social justice in pandemic preparedness. *Health, Policy and Ethics*, 102(4):586-591.

⁵ Norlock, K. (2019). Feminist Ethics. *The Stanford Encyclopedia of Philosophy* (Summer Edition), Edward N. Zalta (ed.) <https://plato.stanford.edu/archives/sum2019/entries/feminism-ethics/>



New Zealand College of Midwives

TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

personal protective equipment (PPE) in the ethical framework document (pp. 20-23), access to personal protective equipment (PPE) for community midwives was problematic in the first two weeks but improved in the subsequent weeks. In some hospitals, there was rationing of PPE in hospitals and birthing units, and in some cases PPE was locked away and inaccessible for immediate use. The lack of access to PPE increased anxiety for midwives who were concerned about being vectors for infection. This information comes directly from a survey of midwives conducted by the College which included generic questions as well as separate sections for hospital and community midwives to understand the particular pressures, additional work and costs associated with COVID-19. The College received more than 700 responses to the survey.

11.0 There was a time lag between identification of guidance and sign off of that guidance which caused confusion and anxiety. The development of guidance requires a streamlining approach in future pandemics so that health professionals can access guidance that is up to date, time specific and fast.

12.0 The midwifery workforce was able to adapt to ensure that women were able to continue to access maternity care under a state of emergency. However, community midwives in particular were faced with many additional costs. In order to ensure that the midwives are appropriately supported and reimbursed there is a need for immediate access to resources for primary community midwifery services to support them so that they are able to continue their essential work during pandemic responses.

13.0 The College considers that midwives, as a designated essential workforce, should be included in those workers deemed to be "in need" ("those who take greater risks because of their health care or other roles"), when decisions concerning prioritisation for distribution of harm reduction resources such as PPE are made (p. 20 – Prioritising the people most in need).

14.0 The College agrees that communities who have been marginalised and who suffer poor health and social outcomes due to inequity should be involved in all decision making about what resources are needed and how these resources should be distributed (P. 21) (See 5.0).



New Zealand
College of Midwives

TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

Conclusion

Thank you for the opportunity to provide feedback on this document. The COVID-19 pandemic response required rapid change, adaptability and flexibility to support health care and service delivery. The midwifery workforce is adaptable, flexible and meets women needs during times of crisis. The NZ maternity care model that provides continuity of care from a LMC midwife provides a flexible service that supports women's needs. This model of care becomes even more important during times of emergency and disaster.

Pandemics will continue to be a risk globally, and to avoid future catastrophe Aotearoa New Zealand needs to urgently address factors that exacerbate ill health such as institutionalised racism, poverty, and the social, political and commercial determinants of health, fairness and justice.

There is also a need to examine and address the wider environmental picture which could be considered under a broader resource allocation framework and which encompass water quality, climate crisis and food security, because concerns about climate change have a significant negative effect on mental health and wellbeing, and climate change must be considered as a significant threat to human health, as well as pandemics.

Ngā mihi

New Zealand College of Midwives

Te Kāreti O Nga Kaiwhakawhanau Ki Aotearoa



National Ethics Advisory Committee

Kāhui Matalika o te Motu

Ethical Framework for Resource Allocation in Times of Scarcity

Commented [DC1]: Our group feels that the title indicates the document relates to times of scarcity in general. There is reference in the body of this document to the 2007 document "Getting Through Together: Ethical values for a pandemic" which is to be further updated, presumably in light of this new document. We feel the title of the present document should indicate its COVID-19 focus.

June 2020

National Ethics Advisory Committee | Kāhui Mataiāka o te Motu

Citation: National Ethics Advisory Committee, 2020. *Ethical Framework for Resource Allocation in Times of Scarcity*. Wellington: Ministry of Health.

Published in June 2020 for the National Ethics Advisory Committee – Kāhui Mataiāka o te Motu by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN: 978-XXXX (online)
HP XXXX

This publication is available on the National Ethics Advisory Committee website:



www.neac.health.govt.nz

Contents

National Ethics Advisory Committee – Kāhui Matatika o te Motu	1
Members of NEAC.....	1
Members of the secretariat.....	1
Acknowledgements.....	1
Introduction	2
Key features of the COVID-19 virus.....	2
Te Tiriti o Waitangi.....	2
A focus on equity.....	3
Increasing risk through unequal distribution and exposure to the determinants of health.....	3
Indigenous health inequities in New Zealand.....	4
Human rights.....	4
Ethical principles	5
Introduction.....	5
Tensions between the principles.....	5
Allocation of resources	110
Resources.....	110
Clinical resources.....	110
Public health resources.....	121
Support service resources.....	121
Making decisions.....	121
The decision-making process.....	121
Establishing a decision-making group.....	130
General allocation guidance	143
Should COVID-19 patients be prioritised over patients without COVID-19 in resource allocation?.....	143
How will resource allocation impact electives and routine health care?.....	153

Should the standard of care for patients change in an epidemic?.....	1514
How will data be collected and shared?.....	1515
What are organisations' obligations?.....	1514
Example 1: Intensive care unit allocation	1615
Introduction.....	1615
Applying the principles.....	1615
Prioritising the people most in need.....	1615
Getting the most out of resources.....	1615
Achieving equity.....	1716
All people are equally deserving of care.....	1716
General considerations.....	1716
Example 2: Personal protective equipment allocation	2120
Introduction.....	2120
Applying the principles.....	2120
Prioritising the people most in need.....	2120
Getting the most from the resources.....	2120
Achieving equity.....	2221
All people are equally deserving of care.....	2322
General considerations.....	2322
Example 3: Vaccine allocation	2524
Introduction.....	2524
Applying the principles.....	2524
Getting the most from the resources.....	2524
Prioritising the people most in need.....	2524
Achieving equity.....	2625
All people are equally deserving of care.....	2625
General considerations.....	2625
Bibliography	2827

National Ethics Advisory Committee – Kāhui Matatika o te Motu

The National Ethics Advisory Committee – Kāhui Matatika o te Motu (NEAC) is an independent advisor to the Minister of Health (the Minister). The members of NEAC are appointed by the Minister and bring expertise in ethics, health and disability research, health service provision and leadership, public health, epidemiology, law, Māori health and consumer advocacy.

NEAC published *Getting Through Together: Ethical values for a pandemic in 2007* (NEAC 2007). *Ethical Framework for Resource Allocation in Times of Scarcity* builds on the work of *Getting Through Together*.

Members of NEAC

Māureen Holdaway, Kahu McClintock, Wayne Miles, Neil Pickering, Li: Richards, Hope Tupara, Dana Wensley, Gordon Jackman, Mary-Anne Woodnorth.

Members of the secretariat

Nic Aagaard, Rob McHewik, Hayley Robertson, Martin Kennedy, Matthew Prulson, Tristan Katz.

Acknowledgements

The ethical framework for making resource allocation decisions was developed by NEAC, with support and advice from Angela Ballantyne, Kim Dargaville, Cherec Shortland-Nuku and Helen Whrongi.

Introduction

As a result of COVID-19, we are experiencing an increasing demand on our health care system and its resources. Clinical professionals and public health officials are likely to have to make decisions about situations they have never experienced before. This framework has been developed to help clinicians, nurses, hospital administrators and public health policy makers i)mitise distribution and prioritisation of vital resources in times of scarcity.

NEAC emphasises 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 and does not consider all potentially scarce resources or all potential decisions.

NEAC note that this document is in response to the COVID-19 pandemic. NEAC intend to develop this document to be more generally applicable to pandemics as part of their wider work program, which involves updating *Getting Through Together: Ethical values for a pandemic*.

Key features of the COVID-19 virus

The virus can spread from person to person through:

- close contact with an infectious person (including in the 48 hours before that infectious person exhibits symptoms of their infection)
- contact with droplets from an infected person's cough or sneeze touching objects or surfaces (such as doorknobs or tables) that have droplets from an infected person and then touching your mouth or face (Australian Government Department of Health 2020).

COVID-19 is a new disease, so there is no existing population immunity. This means that COVID-19 can spread widely and quickly.

Symptoms of COVID-19 can range from mild illness to acute respiratory distress syndrome (ARDS). Some people will recover easily, others may get very sick very quickly, and some will die.

Te Tiriti o Waitangi

Te Tiriti o Waitangi / the Treaty of Waitangi (Te Tiriti) is one of the major sources of New Zealand's constitution. Te Tiriti creates a basis for civil government encompassing all New Zealanders. The Government continues to respond to its obligations to honour Te Tiriti. Te Tiriti mandates that Māori participate in equal partnership with the Government. To this end, Māori must have protection and receive acknowledgement of their rights and interests within their shared citizenship.

Commented [DC(2)]: Allied Health needs to be mentioned also.

Commented [DC(3)]: As we now know more about this illness it would probably be more accurate to say "multi-organ failure" here instead.

Commented [DC(4)]: In addition it is worth mentioning that recovery can be prolonged with protracted impact on healthcare services.

The New Zealand health and disability system has a responsibility to contribute to meeting the Crown's obligations under Te Tiriti. As an independent advisor to the Minister, this ethical framework supports the New Zealand health and disability system in meeting its obligations under Te Tiriti by drawing on the principles of Te Tiriti as articulated by the courts and the Waitangi Tribunal and considering their implications for resource allocation decisions.

Supporting the New Zealand health and disability system to meet its obligations under Te Tiriti is necessary if we are to ensure iwi, hapū, whānau and Māori communities are active partners in preventing, mitigating and managing the impacts of a pandemic or public health emergency on whānau, hapū, iwi and Māori communities (Ministry of Health 2020).

A focus on equity

Pandemics and other public health emergencies often have the biggest impact on marginalised communities. Pandemics highlight and exacerbate already existing inequities within the health system. For this reason, NEAC provides ethical guidance and notes the importance of considering equity in resource allocation. Equity recognises that different people with different levels of advantage require different approaches and resources to achieve equitable health outcomes.

Increasing risk through unequal distribution and exposure to the determinants of health

This framework recognises that every person is of equal moral worth. However, significant health inequalities exist among different groups of New Zealanders. This difference in health status between groups is influenced by socioeconomic factors and compounded by structural inequities, such as racism and discrimination. Structural inequities systematically disadvantage individuals and groups based on ethnicity and social positioning (i.e. age, gender, ability). This results in the unequal distribution of power and resources and differentiated access and exposure to the acknowledged determinants of health. Research persistently shows that Māori, Pacific peoples and people from lower socioeconomic demographics experience worse health and die younger than other New Zealanders (Ministry of Health 2020).

Disabled people are of equal value and have the same rights as all other New Zealanders. Yet an underlying, pervasive and often unquestioned devaluing of disabled people exists called 'ableism'. When ableism intersects with ageism and/or racism, it can compound discrimination and specific human rights violations, deprioritisation in access to resources and poorer-quality health services.

Māori, Pacific peoples and disabled people, older people, people with intellectual and psychosocial impairments and those with chronic health

conditions, co-morbidities, dependence on ventilators and compromised immunity face are even more vulnerable during the COVID-19 pandemic.

These factors are particularly relevant when allocating clinical resources during a pandemic.

Indigenous health inequities in New Zealand

Māori experience higher rates of infectious diseases than other New Zealanders (Ballantyne 2020). For COVID-19, older people and individuals with underlying conditions are at increased risk of severe infection. Māori as a population have higher rates of chronic conditions and comorbidities and are therefore more likely to develop severe COVID-19 as a result of contracting SARS-CoV-2 infection. In addition, Māori often have more people living in their households, which places more people at risk from exposure to infectious diseases – but conversely, more people in the household stand to benefit from preventative actions.

Human rights

This framework is underpinned by all people's right to good health, including access to necessary resources, as expressed in article 25 and the preamble of the Universal Declaration of Human Rights (United

Nations 1948).¹ Human dignity is the ultimate foundation of all human rights and fundamental freedoms.

¹ Article 25 reads: Everyone has the right to a standard of living adequate for the health and well-being of themselves and their family, including ... medical care ... And, in the declaration's preamble the General Assembly of the United Nations proclaims that ... every individual and every organ of society ... shall strive ... by progressive measures, national and international, to secure their universal and effective recognition

Ethical principles

Introduction

This section sets out four resource allocation principles and four Tiriti principles (tables 1 and 2 respectively).

This framework does not prioritise the principles ethically or conceptually. However, the two sets of principles do have one important common ground: they highlight the important factors, particularly for Māori, that must be considered when allocating scarce resources. Importantly, the way they are applied will vary depending on the resource being considered, the level of scarcity and the context (clinical or public health).

Tensions between the principles

NEAC holds that having multiple principles reflecting a plurality of values is the best basis of ethical decision-making. It may be that in some circumstances different principles can be followed at the same time. For example, in some elective surgeries, prioritising those with most need and achieving the most benefit might be considered in tandem to achieve the best result. But in a pandemic (as with many other contexts), values and principles can conflict.

For example, with COVID-19, it may not be possible to achieve equity and to benefit the most people possible. As an example, in the case of intensive care unit (ICU) beds or ventilators, the decision might be made to treat those with fewer comorbidities first because this is predicted to be the best way of saving as many lives as possible. Yet, doing so may undermine equity if some groups (such as Māori or disadvantaged people) tend to have more comorbidities than other groups to start with.

From a theoretical position, NEAC's approach fits with the idea that the different and sometimes inconsistent values and principles of ethics are *prima facie*. This means that wherever they are relevant, they are significant, but a particular value or principle may sometimes have to be sacrificed to realise another value or principle, judged of greater weight or significance, in the circumstances. From a psychological standpoint, people will often feel a variety of values pulling them in different directions, experiencing internally the ethical dilemmas described later in this framework around the three examples of intensive care unit allocation, personal protective equipment allocation and vaccine allocation.

The three examples show the tensions that exist between values and principles when making difficult decisions. NEAC believes that good decision-making involves recognising, rather than ignoring, these tensions.

Commented [DC(8)]: "as" rather than "if"
Commented [DC(5)]: Can the origin of these four principles be referenced?
Commented [DC(6)]: It seems to us that it is generally accepted that there are 4 main principles in resource allocation of scarce medical interventions (1) Treat people equally (2) Maximise total benefits from resources (utilitarianism) (3) Favour the worst-off (prioritarianism) (4) Promoting and rewarding instrumental value. Papers quote Persad 2008 lancet paper "Principles for allocation of scarce medical interventions" 373(9661): 423-34] and Callahan D (1987) Setting limits, medical goals in an aging society. Simon and Schuster, New York. This NEAC framework uses principles 1-3, but not 4. We would also be interested to know where "achieving equity" came from, academically/ethically speaking, in the framework, separate to (1) "Treat people equally"
Commented [DC(7)]: As many of the ethical considerations around equity relate similarly to Pacifica, we wonder whether that should be mentioned here.

Table 1: Resource allocation principles

The resource allocation principles chosen reflect the important considerations that are made when prioritising scarce resources. They are in tension and must be considered in light of each resource allocation decision.

Resource allocation principle	Application to resource allocation
<p>All people are equally deserving of care</p>	<ul style="list-style-type: none"> Each person affected by the COVID-19 pandemic in New Zealand deserves equal respect and consideration. Resources should not be distributed arbitrarily or withheld on the basis of individual or group characteristics that are irrelevant to the clinical prognosis, for example, including: race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation¹ (United Nations Committee on Economic, Social and Cultural Rights, 2009).² There must be sufficient evidence to demonstrate that these factors are predictive of prognosis if they are to be used in allocation decisions.] Fair allocation should aim to avoid a first-come, first-served bias.
<p>Getting the most from the resources</p>	<ul style="list-style-type: none"> Resources required for the COVID-19 pandemic response must be managed responsibly. In the context of a health emergency, we should aim to allocate resources efficiently and maximise the clinical benefits. There are several competing interpretations of how best to measure clinical benefit, for example: to maximise lives saved, to maximise life years saved (eg, by prioritising the young to maximise length of lives saved), to maximise the cost-effective use of resources and to prioritise essential workers (such as health care staff) so they can

Commented IDC(9): We would like to ask whether you are saying that those listed factors shouldn't be used for allocation of resources unless they have prognostic relevance? The main point here is avoiding discrimination on the basis of non-prognostic factors, rather than an equity discussion. In my mind those are two different issues that shouldn't be confused.

There is even a risk to equity when using prognosis-predictive factors

Commented IDC(10): Should quality of life (QALY) rather than just length of life be added here. It certainly adds complexity to "benefit" considerations and is controversial as it potentially detracts from equity, especially for disability. You do make a statement about this at page 18 however.

¹ Note also that under the New Zealand Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, right 4, every health consumer has the right to be free from discrimination. See: www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

Resource allocation principle	Application to resource allocation
<p>Prioritising the people most in need</p>	<p>continue to serve and protect the public.</p> <p>There are competing interpretations of how to measure need – the sickest, the most disadvantaged or marginalised, those at greatest risk of harm or those subjected to previous injustices.</p> <p>Prioritising those in need will sometimes align with and sometimes conflict with prioritising those who can most benefit from health resources.</p> <p>One option is to give priority to individuals or groups in greatest need in order to restore them to an appropriate health threshold³</p>
<p>Achieving Equity</p>	<p>In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes. (Ministry of Health nd.)</p> <p>An equity approach would consider how resources can be allocated to mitigate the adverse consequences of pandemic response measures and avoid or minimise growth in inequity deriving from those measures.</p> <p>It is likely to be difficult to ameliorate existing inequity during a public health crisis, however, all efforts must be made to ensure equity is at the forefront of decision-making.</p> <p>The COVID-19 pandemic shed light on existing social fault lines and provided momentum to address entrenched</p>

Commented [DC(11)]: Typo?

³ The World Health Organization stated in the Do No Harm Declaration on Equity Dimensions of Health (WHO 2013) that people have the right to the highest attainable standard of health. The highest attainable standard of health is a reflection of the standard of health enjoyed in the most socially disadvantaged group within a community. This indicates a level of health that is biologically attainable and the minimum standard to what should be possible for even those in that society. See *Advancing Equity in Health Outcomes* Ministry of Health 2013 for more information.

Resource allocation principle	Application to resource allocation
	inequity after the acute emergency had passed.

Table 2: Te Tiriti o Waitangi principles

The principles of Te Tiriti o Waitangi, as articulated by the Courts and the Waitangi Tribunal, provide the framework for how our health and disability system ought to meet its obligations under Te Tiriti in its day-to-day work. The Waitangi Tribunal's 2019 Hauora report recommends a set of principles for the primary health care system that are applicable to the wider health and disability system and are applied to resource allocation principles in table 2 below (Waitangi Tribunal 2019, pages 163–64).

Te Tiriti o Waitangi principles as set out in the Hauora report	Te Tiriti o Waitangi principles' application to the primary health care system	Te Tiriti o Waitangi principles' application to resource allocation
The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery and monitoring of primary health care.	Tino rangatiratanga requires clinicians, hospital administrators and public health policy makers to provide for Māori self-determination.	In a resource allocation setting, this means that Māori are key decision makers in the design, delivery, prioritisation and monitoring of health and disability services and the response to pandemics or public health emergencies.
The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.	Options , which requires clinicians, hospital administrators and public health policy makers to provide for and properly resource kaupapa Māori health and disability services in response to a pandemic or public health emergency.	In a resource allocation setting, this means that the health and disability system is agile in adapting and responding to the pandemic resource needs of kaupapa Māori health and disability services to be able to serve Māori communities.
The principle of active protection, which requires the Crown to act, to the fullest extent	Active protection , which requires clinicians, hospital administrators and public health policy	This requires the clinicians, hospital administrators and public health policy makers to prioritise

<p>Te Tiriti o Waitangi principles as set out in the Hauora report</p> <p>practicable, to achieve equitable health outcomes for Māori.</p> <p>This includes ensuring that the Crown, its agents and its Treaty partner are well informed about the extent and nature, of both Māori health outcomes and efforts to achieve Māori health equity.</p>	<p>Te Tiriti o Waitangi principles' application to the primary health care system</p> <p>makers to act, to the fullest extent practicable, to protect Māori health and achieve equitable health outcomes for Māori in response to a pandemic or public health emergency.</p>	<p>Te Tiriti o Waitangi principles' application to resource allocation</p> <p>resources to actively protect the health of the Māori population and implement approaches to equip whānau, hapū, iwi and Māori communities with the resources to undertake and respond to public health measures to prevent and/or manage the spread and transmission of disease among their people.</p>
<p>The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of primary health services. Māori must be co-designers, with the Crown, of the primary health system for Māori.</p>	<p>Partnership, which requires the clinicians, hospital administrators and public health policy makers and Māori to work in partnership in the governance, design, delivery and monitoring of the response to a pandemic or public health emergency. This contributes to a shared responsibility for achieving health equity for Māori.</p>	<p>In a resource allocation setting, this means that the health and disability system works alongside Māori leaders to enable a coordinated and united response to a pandemic or public health emergency whereby Māori have the resources to govern, design, deliver, manage and monitor a response and the impacts on Māori communities.</p>

Allocation of resources

Resources

When we don't have enough of a particular resource to meet demand, we must decide the best way to distribute that supply of resource: to ensure the most effective results. Resource allocation is the mechanism we use to do this.

This framework applies to extreme measures intended to be implemented only in the worst-case scenario, in which adequate resources are not available. The application of principles and the relative weighting of different principles may differ between emergency and non-emergency situations. For example, a novel COVID-19 vaccine would still need to meet safety and efficacy standards; but it may be ethical to endorse a wide-spread immunisation programme without long-term outcome data.⁴

Ethical resource allocation should not be limited to clinical resources.

There are many different kinds of resources that may become scarce

during a pandemic. Each resource has a different risk/benefit profile and may be rationed or prioritised using a different weighting of the principles; for example, a clinical or medical context in the case of ventilators or a public health context in the case of personal protective equipment.

Support services are an additional category of essential pandemic resources and, if allocated well, they can be useful in mitigating risk for individuals and communities.

This framework could be applied to a variety of resources. Some options are listed below.⁵

Clinical resources

Treatment has burdens and benefits; the decision to allocate a clinical resource is complex and requires assessment of futility/appropriateness of medical intervention, the patient's best interests, the patient's autonomy and the principles of resource allocation. Clinical resources include access to:

ICU

ventilators

Commented IPC(12): The term "distributive justice" is commonly used in like literature. We wonder whether it should be used here also?

Commented IPC(13): Add in all hospital beds as pressure on beds in general certainly constrains other healthcare provision.

⁴ For example, the New Zealand Health and Disability Commissioner (Codes of Health and Disability Services Governance) Rights Regulation. Paragraph 18 states that every health consumer has the right to services of an appropriate standard. It also says that only in "very exceptional" circumstances, such as the rapidly and suddenly changing circumstances of the COVID-19 pandemic, will it be appropriate to temporarily suspend part or all of the resources available.

⁵ The most in-depth expert analysis of triage and health ethics is *An Ethics Framework for Making Resource Allocation Decisions When Care Exceeds Demand* by the University of Sydney.

- palliative care
- medications.

Public health resources

These are clearly valuable goods, typically with minimal risks or downsides. They include:

- personal protective equipment (PPE)
- diagnostics
- clinical expertise
- vaccines.

Support service resources

These are measures that can increase access to services and mitigate adverse impact. They include:

- carers visitation rights (allocating PPE to support this)
- accessible communication (public and patient)
- supported decision-making tools and services
- financial support for home carers
- interpreters
- social workers

- health navigators
- health and disability advocates
- rehabilitation support (given the growing evidence of disabilities associated with critical COVID-19 e.g. Post-Intensive Care Syndrome cases).

Making decisions

The decision-making process

Good decision-making processes confer legitimacy on the final decisions, even when disagreement persists, and may help to resolve ongoing disagreement. They may also help ensure that decisions include comprehensive consideration of relevant issues.

Pandemic planning decisions should be clearly consistent and underpinned by ethical values. A good decision-making process fosters public trust and goodwill towards institutions such as hospitals, leading to greater acceptance and satisfaction and fewer complaints. Such processes identify values recognised in Māori tikanga or kawa (protocol or ceremonial actions) alongside other values.

It has been suggested that 'due process requirements are inherently important because fair hearings affirm the dignity of the person' (Bayer 2007 p. 266). Good decision-making processes may be necessary in

order to show respect for people and ensure procedural fairness. As such, they may also reflect the value of *tika*, in the sense of acting in a way that is just and proper. Māori *tikanga* and *mātauranga Māori* may need to be considered in the context of challenging other values not just sitting alongside those values.

A wide range of views can be present when considering ethical issues, and it is common to have a lack of consensus about which values and principles are the most important on which to base a decision. This is another reason why we need to develop acceptable, fair processes.

Establishing a decision-making group⁶

NEAC recommends that a decision-making group be established in appropriate health services institutions at both the national and local level, as necessary. Each institution will need to consider the kind of membership for their decision-making group that will work best for them. Each group should include the perspectives of their particular institution's patients, Māori, disabled people, clinicians, ethicists, legal and any other relevant stakeholders who will be impacted by the decisions the group will be making. The group should:

- frequently re-evaluate their allocation criteria since the application of ethical frameworks should be a fluid process that moves back and forth along a continuum contingent on available resources and as the understanding of the spread, pathophysiology, treatment and outcomes of COVID-19 infection evolves;
- determine the best way of communicating clearly and consistently to appropriate personnel about when crisis level allocation or re-allocation is and is not in effect
- take into account Te Tiriti articles and principles and their application to resource allocation
- consider plans for ensuring staff safety, maintaining clinician-to-patient ratios, training additional personnel, supporting organisational resiliency and providing support resources for staff (child care, payment, sick leave, etc.)
- ensure appropriate communication with patients, the local community and the broader general public about plans for scarce resource allocation
- maintain communication links between local and national responses.

In the clinical context, a key aim is to separate care and advocacy for a particular patient from the allocation decisions. This provides a level of detachment from the immediate clinical needs of each patient, better

Commented [DC15]: One framework has 4 levels of scarce, really scarce, extremely scarce, failure of hospital etc... which broadly suggested how patients and treatments would be managed....

⁶ The recommendations in this section are based on information from *Ethics of Emergency and Resource Allocation for COVID-19 Resources*, Association of Bioethicists, University of Virginia Health System Ethics Committee, 2019.

ensuring a clear and defensible decision-making process around resource allocation, thereby reducing the opportunities for accusations of bias. It also has the advantage of protecting those clinicians caring directly for patients from some of the direct stress and anxiety of being the decision-makers about allocation.

In the public health context, establishing a group allows transparency and clear communication between the national and local levels. It also ensures a clearer path to engaging with local communities.

General allocation guidance

Should COVID-19 patients be prioritised over patients without COVID-19 in resource allocation?

NEAC agrees with *Sydney Health Ethics: An Ethics Framework for Making Resource Allocation Decisions within Clinical Care: Responding to COVID-19* that there are no ethically defensible grounds to prioritise an infected patient over any patient who is not infected (University of Sydney 2020).⁷

How will resource allocation impact electives and routine health care?

If resources, such as clinical expertise, become scarce, it may be necessary to prioritise responding to the pandemic over non-essential interventions (elective surgeries, cancer screening) that can be postponed. However, such a decision could have significant health impacts for individuals and should not be taken lightly. The decision is grounded in two interrelated justifications. The first is to reduce the spread of COVID-19. The second is to prepare for a potential swell of COVID-19 patients.

Postponing non-essential interventions necessarily involves a trade-off between the harm caused by postponing routine care and the potential harm of health systems being overwhelmed. Decisions relating to postponing non-essential interventions, need to be continually reassessed. National instructions to prohibit non-essential services may cause harm if they are applied to organisations in regions that do not have a high risk of COVID. The decision-making group needs to make its decisions based on local and/or regional data.

The group also needs to give explicit consideration to the implications of tikanga and mātauranga Māori, including involving tikanga experts in the discussion when making decisions about standards of care in times of crisis.⁸

Commented IDC(17): We feel the term "non-essential" which has been used in wider community contexts during the Covid-19 response could provoke argument. Perhaps a term such as "less essential" or "less urgent"?

Commented IDC(16): Our group is not sure of this, more from a clinical perspective though, which feeds into the decision-making. The Sydney framework highlights that in times of scarcity, "our primary obligation is to ensure that we gain the best value we possibly can from the expenditure of that resource". I don't think Covid patients should be prioritised simply because of a positive test, but they can become extremely sick, and might benefit the most from those intensive resources... The Sydney framework does agree that we should prioritise the pandemic over other non-essential interventions. I wonder whether there would be ethical grounds for this, based on "labouring the worst off". The mortality rates of patients with Covid who are admitted to hospital are really high (30%), and even higher if they end up in ICU. Very few diseases carry these sorts of mortality and morbidity rates.

Commented IDC(18): Whilst in no way wishing to detract from the pre-eminent importance to these discussions, we wonder whether mentioning Pacific peoples in this part of the document may also be important given their similar vulnerability? And Asians? This is a difficult balance because Te Tiriti is between Māori and Pākehā / British crown, and in effect all others after this (Pacific, Asian...) are in the latter category. Although Pacifica are marginalised and in a disquietable position, if they are mentioned then Asian, and all other groups' cultural issues/implications should also be. At least one of our group feels this sentence should stay as it is.

Should the standard of care for patients change in an epidemic?

Patients should receive the best available care during a pandemic. However, the range of options for what is 'best' could well change as a result of the constraints imposed by a pandemic. For example, patients may not be allowed to have visitors (especially when PPE is scarce). This will be necessary to protect staff and other patients and reduce the risk of transmission from and to visitors.

This could mean that some patients become seriously ill and die without the usual support of relatives and friends. This will inevitably cause distress to all parties. Access to other modes of communication, such as phone and video calls, should be provided where possible. It is important that all organisations inform the public about any changes to standards of care before such changes are introduced (University of Sydney 2020).

Where patients who are not infected are discharged earlier because of the concerns of a pandemic, those patients should receive more extensive continuing care at home to ensure they are not disadvantaged (University of Sydney 2020). This could be achieved through increased telehealth services, and should only occur when clinically appropriate.

How will data be collected and shared?

Data sharing between different institutions is critical in effective resource allocation. For example, there may be opportunities for district health boards (DHBs) to share resources, depending on the extent of impact of COVID-19 in each region. It will be important to ensure that adequate care standards are in place to protect privacy and maintain confidential communications – crisis standards of care do not weaken the fundamental obligation to protect the privacy and confidentiality of patients.

Collecting high-quality ethnicity and disability data for monitoring is fundamentally important. Data collection and sharing enables the response measures and allocation decisions to be monitored and tailored to respond promptly and effectively to evidence of inequitable impacts and outcomes.

What are organisations' obligations?

Organisations must share information, adjust protocols, and balance resources and patient loads across their immediate surrounding region to ensure as consistent a standard of care is maintained as possible. Public health decisions should be transparent.

Commented [DC19]: We feel that it would be worth adding here that one of the impacts on standard of care may be that clinicians may be required to work outside their usual scopes of practice or usually accepted workloads. For example, in other countries there has been an impact on the best standard of care in ICU where overworked nursing staff received support from non-ICU credentialed nursing staff from other wards. This is especially so where additional ICU beds are provided for a pandemic onslaught.

Example 1: Intensive care unit allocation

Introduction

In order to show fairness and sustain public trust, we need to implement triage guidelines consistently throughout New Zealand. Solidarity requires that resource allocation reflect our common interest in addressing any pandemic; collaborative regional cooperation may require the reallocation of resources between health services based on differential need. Clear and consistent triage guidelines and triage committees can reduce the moral injury and distress frontline health workers can experience during a pandemic.

Current approaches of 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 classes, Māori, Pacific peoples and people with disability.

There are several tensions to be considered when allocating resources in the clinical setting, as there is the additional consideration of clinical

appropriateness to take into account, which may limit the ability for equity to be fully realised.

Applying the principles

Prioritising the people most in need

Patients with the most severe disease who are most likely to die or suffer without treatment should be prioritised for ICU access. Often this principle will align with getting the most out of resources because the sickest patients will be most likely to benefit from ICU care. However, some patients will fall below a threshold where they are so sick there is minimal chance of their survival, even with ICU intervention.

Getting the most out of resources

Most critical care triage guidelines prioritise saving lives as the primary ethical value. For example, resources should be allocated to patients with the greatest capacity to benefit from ICU. This is often defined as the likelihood of surviving an ICU admission and for one year following discharge (Bideson 2018). This principle conflicts with the principle of achieving equity of clinical outcomes.

Giving priority to individuals who have the most chance of benefiting from treatment in ICU may achieve the aim of saving the maximum number of lives. But greater ability to benefit is often associated with

Commented [DC(21)]: Again, further to our comment before about prioritising Covid patients, they are some of the sickest patients that we would see, who are most likely to die without treatment....

Commented [DC(22)]: It is unclear whether this statement relates to Covid patients only or all patients where ICU is indicated

Commented [DC(23)]: This term is confusing. Less confusing would be "However, some patients will be so sick there is minimal chance of survival..."

Commented [DC(20)]: including age and likelihood of recovery

wider determinants of health, such as higher socioeconomic status. Socioeconomic status in turn may be systematically distributed to some groups and away from others. As a result, a socioeconomically advantaged group may be more likely to be represented among those individuals selected for ICU. Where reduced ability to benefit by reason of socioeconomic disadvantage is linked to injustice, this results in a tension with the value of equity.)

Achieving equity

Given the unequal distribution of comorbidity and multi-morbidity amongst the New Zealand population (for example on the grounds of socioeconomic deprivation and ethnicity), it will be very difficult to avoid unequal outcomes based on demographic factors.

For critically ill COVID-19 patients, the primary consideration should be whether ICU care is in the patient's best interest and what other care may be appropriate, including palliative or supportive care. When ICU space is severely limited, there will be tension between utility (saving the most lives) and equity (ensuring fair outcomes between groups). This tension cannot be resolved via ethical analysis at the stage of admission to ICU, as clinical considerations take precedent at that stage.

All people are equally deserving of care

Disability status or age must not be used as a simple proxy for health status or capacity to benefit. Screening measures, including the quality-adjusted life year (QALY) measure, must be avoided as they are inherently biased against people with disabilities. Triage decisions should be based on assessment of an individual's personal medical history (noting the tendency for medical records to be error-prone).

General considerations

The following considerations have been adapted from Maves et al (2020).

When implemented, triage guidelines must be applied to all current and new patients presenting with critical illness, regardless of the diagnosis of COVID-19 or other illness

NEAC recommends an independent decision-making group be established to enact a triage plan.

It is important to ensure that patients who do not initially receive critical care resources are still provided with the best supportive care possible and are re-evaluated regularly for consideration of resource allocation, as supplies become available.

Commented [DC(24)]: Injustice as stated here presumably refers to that existing prior to the pandemic. Given the likelihood of subsequent pandemics, we wonder whether it would be worth highlighting here that one of the drivers to correcting institutionalised injustice should be to improve the potential to benefit in subsequent pandemics?

It could even be "anti-utilitarian" where fewer people overall in a society survive or benefit.

Commented [DC(25)]: Our group had considerable discussion around this point. We are not entirely comfortable with the idea that there is ever a point in relation to scarce resources where equity could be overwhelmed. We would welcome the opportunity to discuss this further.

One of our group is aware of a Dutch Royal Medical Association and Federation of Medical Specialists document describing a 3 phase escalation model with regards to ICU triage. Level 3 (code black) has 3 phases. Phase C being where strict triaging on medical grounds is no longer sufficient and triaging occurs on the basis of ethical principles.

We are also aware COVIDHB feel that in such a situation a "1000 minds approach" could work if such issues as "reverse triage" were to be addressed (Triage patient out of intensive care to allow other to be triaged in.

Another of our group thinks your statement is reasonable, that all you are saying is that at the time a sick patient presents, the clinical concerns about the patient in front of the ICU doctor will always take precedence over societal-based equity discussions, which can't be held acutely at that point and are more generic/global and can't be on-the-spot decisions. You are presumably saying one can't solve equity issues at the front door of ICU in the middle of a pandemic...

Patients who are unable to receive invasive mechanical ventilation may be able to receive supplemental oxygen through a non-invasive route as resources permit.

The implementation of early palliative care interventions can provide a better quality of life, less treatment intensity, and no consistent impact on mortality (Maves et al. 2020). This offers a strong rationale for carefully integrating symptom management alongside palliative care principles for all patients who are impacted by crisis care.

There is no ethically significant difference between withholding and withdrawing life-sustaining treatment; but health care providers, patients and families often find decisions to withdraw treatment more emotionally and psychologically challenging.

Time trials of ICU may be necessary to manage patients and families' expectations and avoiding prolonged stays in ICU with minimal and decreasing prospects of benefit. Clear criteria and schedules for reassessing patients on time trials will be necessary.

ICU care may be ethically withdrawn when it is no longer in the patient's best interests (harm of treatment now outweighs the prospect of any benefit). Decisions about the patient's best interests must follow the process and principles of right 7(4) in the Health and Disability

Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.⁷ Care may also be ethically withdrawn if it is judged to be medically inappropriate because the prospect of benefit falls below a predetermined threshold.

Depending on the demand for care within ICU, estimated length of stay per patient and epidemiological surge projections, hospitals may be justified in keeping some ICU beds empty in order to be prepared to care for subsequent high-priority patients.

Health care should not be denied or limited based on quality of life judgements (Maves et al. 2020).

Commented IDC(26): This phrase is inaccurate, as symptom management is an intrinsic part of palliative care, and palliative care does not just mean dying. The WHO definition is "Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual". I would suggest that it says instead "This offers a strong rationale for carefully integrating early palliative care for all patients who are impacted by crisis care".

Commented IDC(28): What would be the ethical support for this? If it is agreed that first-come first served is not ethical, and that people can be taken off ICU if there is another patient more likely to benefit, then there would be no need to leave beds arbitrarily empty, and potentially leave people to die who might need that support in the interim.

Commented IDC(27): There have also been ethical discussions and papers on withdrawing treatment when another person is more likely to benefit from them, and there are a number of authors who believe this would be ethically justified in the case of pandemics. This is also important as first-come first served is not ethically justifiable in this situation. The NEAC framework here seems to be using usual ethical principles, not the principle of "Best value" out of resources, as would be justified in a pandemic situation. I think this is important and appears to be missing from this document at present.

⁷ See: www.hdc.org.nz/your-rights/abuse-the-right-to-health-and-disability-services-consumers-rights/

Table 3: Assessment of the impact of mechanisms suggested in literature to prioritise scarce resources against the resource allocation principles

Mechanisms	All people are equally deserving of care	Getting the most from the resources (population health)	Achieving equity (achieve 'more' equal outcomes)	Prioritising the people most in need
Clinical scoring + prognosis (eg, SOFA score, clinical frailty, co-morbidities)	Assesses all patients by the same standard and therefore ensures consistency. Need to ensure that disability status and age are not used as proxies for capacity to benefit and that QALY assessments are excluded.	Will successfully maximise the most efficient use of resources to minimise population mortality and morbidity	Will not achieve equitable outcomes between groups because of the unequal distribution of health status amongst the population, including disparities according to ethnicity, disability and socioeconomic status.	In many cases, will result in high priority for the sickest patients: but will exclude the very sickest patients who fall below a threshold where there is minimal chance of survival to ICU discharge (or one year after discharge).
Randomisation / lottery	Gives everyone an equal chance.	Does not ensure the efficient use of resources to maximise benefit.	Should achieve relatively equitable outcomes between patients/groups, at least amongst those who have access to health care and present for triage assessment.	Does not prioritise those with the most need.
Priority for health care and frontline	Does not treat all patients' equally because	Supports population health if (1) priority access to	May support equitable outcomes if we believe that primary health	May prioritise those in greatest need if we interpreted need as

Mechanisms	All people are equally deserving of care	Getting the most from the resources (population health)	Achieving equity (achieve 'more' equal outcomes)	Prioritising the people most in need
workers (eg, cleaners)	it gives priority to some classes of patients based on their employment status and perceived social utility.	treatment acts as an incentive for essential frontline workers to continue to work before infection (and/or (2) means essential frontline workers recover from critical infection and can resume work. (These assumptions would need to be tested with empirical evidence.)	care and frontline workers are fairly entitled to priority access due to the special burdens they have carried on behalf of society.	those at greatest risk of harm; evidence suggests that health workers and, in some case, frontline workers are at significantly increased risk of contracting a pandemic infection, such as COVID-19.

Commented [DC(29)]: This needs rewording.

Commented [DC(30)]: It is likely that many healthcare workers would agree with this. The outpouring of gratitude toward healthcare workers in communities where Covid has been prevalent suggests there may be at least partial acceptance of this as a principle. The ethical difficulty would be applying the principle to two sick individuals, both needing and likely to benefit from ICU but only one bed, and one of the two being a healthcare worker. The community may feel quite differently about that because it does cloud equity.

However, having more healthcare workers working means that more patients can be cared for, which might enhance equity?

Example 2: Personal protective equipment allocation

Introduction

COVID-19 is an easily transmissible infectious disease. Personal protective equipment (PPE) is an important component, but only one part, of a system protecting staff and other patients from cross-infection of easily transmissible infectious diseases and can be considered a harm reduction resource since appropriate use significantly reduces risk of viral transmission.

During a pandemic, PPE must be prioritised and allocated based on proportionate and reasoned guidelines. Overuse of PPE is a form of misuse and should be avoided.

Applying the principles

Prioritising the people most in need

Because the principle getting the most from the resources in this case is defined in terms of harm minimisation, this will for the most part align with prioritising the people most in need. For both principles, we should prioritise those at greatest risk (both of infection and risk of severe COVID-19 mortality).

'Need' can relate to several distinct criteria. In the case of PPE, these include: the need to reduce the chance of contracting infection by those who take greater risks because of their health care or other roles; the need to protect those who are most likely to contract COVID-19 through contact with carers; the need to preserve the welfare of those who are most affected by COVID-19 (eg, those who are dying and their families)

Another option is to prioritise populations that are particularly impacted by COVID-19

Getting the most from the resources

Distribution of PPE should minimise infection rates of COVID-19 (and other pathogens) in order to reduce mortality and morbidity from COVID-19 (and other diseases) across the population.

This takes account of the risk of exposure and the risk of infection resulting in severe COVID-19 morbidity or mortality. Some groups may be at high risk of exposure but low risk of severe COVID-19 or vice versa.

Risk of harm to providers contracting COVID-19 within the health care system will vary according to:

- the nature of the clinical encounter, that is, intubation is more dangerous than transporting patients
- the infectious status of the patient, that is, the patient has confirmed, suspected or does not have COVID-19
- other patient characteristics, for example, they are agitated or violent
- other health provider characteristics, for example, comorbidities or age.

When distributing limited PPE to clinicians during a pandemic, an egalitarian approach that treats all clinical roles as equal may not serve the principle of getting the most from the resources.

'Social worth' is an interpretation of this principle that may be ethically justified in the unique setting of a pandemic.

This recommendation arose from the recognition that some members of society are critical to a successful response to a pandemic.

Applied to PPE, social worth would require assessment not of how many lives a clinician could save, but of the instrumental value of that clinician in providing patient care, both during and after the pandemic.

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.

Achieving equity

Equity requires that distribution of PPE be prioritised to protect marginalised groups and prevent or improve inequality around the risk of contracting COVID-19 or of suffering from a severe COVID-19 infection. This can be achieved by recognising epistemic authority, that is, listening to marginalised groups regarding what they need and how best to distribute resources ... they have valuable and specialist knowledge about their own needs.

Examples include, working with iwi and Māori health groups to ensure the needs of Māori are met and Māori are involved in or control distribution within their communities.

Commented [MH31]: Add Pacific peoples?

Similarly, it is important to work with consumer and interest groups, for example the Disabled Persons Assembly NZ (DPA), to ensure disabled people are not left behind.

Equity may also require additional provision of PPE to Māori health providers and PPE provision to groups in which Māori and Pacific peoples are more highly represented, for example care home workers.

All people are equally deserving of care

Seniority within the health system or organisational hierarchy is irrelevant to PPE distribution. The only exception would be staff with critical expertise whose absence would disproportionately impact the system's ability to provide adequate treatment. Where this justification is used, the reasoning must be transparent.

PPE should not be diverted from standard clinical use in the treatment of other diseases or conditions (eg, surgery); expect when the risk of exposure and harm from COVID-19 exceeds the risks related to those other applications.

General considerations

The following considerations have been adapted from Bean et al 2020

If staff are not provided with adequate PPE, their ethical and legal obligations to work in such environments may be weakened (Schukienk 2020).

Staff have an ethical obligation, based on their obligation to patients and colleagues, to contribute to a safe working environment. This includes the obligation to raise concerns about inadequate PPE. Managers must ensure clear and safe communication channels are available. Staff should not be censured or reprimanded for raising reasonable concerns about PPE supply.

Organisations should implement clear decision-making plans, with regular communication and centralised and coordinated distribution.

As with vaccines, prioritisation of health care workers can be justified on several grounds: because of their increased risk (protect the vulnerable) and their instrumental role in maintaining essential social services (best use of resources) and in recognition of the greater burdens they are carrying on behalf of society before the development of any vaccine (reciprocity).

In order to optimise PPE availability, health systems must coordinate and cooperate to minimise the need for PPE, coordinate supply chain

Commented [DC(33)]: The comment below refers to this also

Commented [DC(32)]: The principle seems reasonable. It may however be impracticable through causing dissent between otherwise equivalent healthcare workers. A more practicable approach and possibly more utilitarian one would be that where a patient population is of higher vulnerability, or the workforce had members of higher vulnerability, those of greater vulnerability would benefit if **all** used PPE (given that PPE potentially has bi-directional protective effects).

and distribution, and use PPE effectively and appropriately.⁸ This is supported by the ethical value of solidarity.

Ensuring effective use of PPE requires appropriate training in infection prevention and control (IPC) to be rolled out in conjunction with PPE.

In order to conserve PPE, visitors should be restricted. Equity requires that exceptions be made for minors or disabled patients who need access to careers] and, in some cases, for patients at the end of life. Where visitors are permitted, they should be provided with clear instructions about how to put on and remove PPE and about performing hand hygiene before putting on and after removing PPE. The instructions should be provided under the supervision of a dedicated health care worker.

Telehealth services can also help conserve PPE.

As described above, cancelling non-urgent or elective procedures that require use of PPE can assist in responding to pandemic outbreaks. However, such restrictions should be continually reassessed.

⁸ For specific guidance, see WHO (2020)

Commented [DC(34)]: carers?

Example 3: Vaccine allocation

Introduction

Safe and effective vaccines are the straightest route to controlling the COVID-19 pandemic. When a vaccine is developed, demand will likely exceed immediate supply and decisions regarding prioritisation will be necessary.

In the case of the COVID-19 pandemic, as there is currently no approved vaccine, this section comments on general ethical principles and priorities for a COVID-19 immunisation programme.

Such a programme must be driven by the science of the vaccine, including vaccine efficacy using both the recommended full schedule and less than the full schedule, course of vaccine administration, contraindication and vaccine safety considerations, vaccine presentation (eg, multi-dose presentation), cost of the vaccine and vaccine supply (whether sufficient quantities can be purchased or produced locally). Immunisation must be based on sound infection control principles developed from the best available immunological, epidemiological and clinical evidence. Pharmacovigilance and

surveillance to monitor for adverse events and effectiveness will be especially important given the anticipated lack of long-term safety and efficacy data.

Applying the principles

Getting the most from the resources

An immunisation programme should aim to maximise the benefit of a vaccine in reducing national mortality and morbidity as a result of COVID-19 and enable the functioning of essential social services.

Prioritising the people most in need

Vaccine allocation could also prioritise people who are the most vulnerable to contracting COVID-19 and/or developing severe COVID-19 disease. Vulnerability depends on both biological and social features.

Priority may be given to individuals with inadequate or limited capacity to respond to the COVID-19 using non-pharmacological public health measures (eg, social distancing, PPE).

Priority may be given to individuals whose work is essential for maintaining health care systems and pandemic response and essential social services.

in relation to vaccination, protecting the most vulnerable and those at highest risk typically aligns with the principle of maximising the population benefit of vaccines;

Some people with underlying health conditions or pre-existing comorbidities will be vulnerable to developing severe, severe or critical COVID-19 infection and at increased risk of dying or suffering serious and possible long term COVID-19-related morbidity.

Other people will be vulnerable because of their social situation or role, including frontline health workers at high risk exposure to COVID-19 patients and people with less capacity to socially isolate (eg. prisoners or those in residential care facilities).

Achieving equity

Vaccine allocation should avoid remediable differences among groups of people based on social, economic, demographic or geographic factors. An equitable immunisation programme will require:

- recognition of epistemic authority (Vulnerable and marginalised communities have valuable understandings of their own needs)
- allocation of resources to protect and promote the interests of vulnerable or marginalised populations
- funding for equitable access to vaccines, including funding for programmes for Māori to design and deliver vaccine programmes to

their own communities. Affordability and access must not become barriers to widespread vaccine availability.

Vaccine allocation should try to avoid or minimise compounding disadvantage by ensuring those who are not prioritised for access to vaccines receive other essential resources, such as PPE or priority access to health care.

All people are equally deserving of care

All individuals' interests should count equally; and all people should be assessed against the same criteria for access to a vaccine.

From an epidemiological perspective, all individuals living in a geographic area (such as New Zealand) must be considered as part of the immunisation programme, regardless of their immigration status. This includes all non-residents currently living in, or unable to leave, New Zealand.

General considerations

Vaccines are beneficial to individuals and populations.

Efforts to control the COVID-19 pandemic at the national level will only succeed with a coordinated regional and global strategy. New Zealand should participate in and support international conversations about fair vaccine allocation globally.

Commented [DC35]: ...and has been generally accepted in relation to measles and flu epidemics -- until of course there is scarcity well below a population's expectation.

There is a potentially interesting discussion here -- there are some researchers who are now saying that older people are less likely to benefit from a Covid vaccine, as their immune systems are weaker and less reactive, and so there could actually be a situation where the priority would be to vaccinate the people who will be most likely to catch Covid (people working, out in society, healthcare etc) but actually less likely to suffer harm themselves, in order to protect the most vulnerable.