Australasian College for Emergency Medicine

Australian and New Zealand College of Anaesthetists

College of Intensive Care Medicine of Australia and New Zealand

New Zealand College of Public Health Medicine

Royal Australasian College of Medical Administrators

Royal Australasian College of Surgeons

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The Royal Australian and New Zealand College of Ophthalmologists

The Royal Australasian College of Physicians

The Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Radiologists

The Royal College of Pathologists of Australasia

The Royal New Zealand College of General Practitioners

Royal New Zealand College of Urgent Care

Australasian College of Sport and Exercise Physicians

Council of Medical Colleges in New Zealand

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24 July 2020

Nic Aagaard
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Health System Improvement and Innovation
Ministry of Heath

By email: neac@health.govt.nz

Tēnā koe Nic,

Re: NEAC Ethical framework for resource allocation in times of scarcity

Thank you for the opportunity to comment on the above framework. The Council of Medical Colleges (CMC) is the collective voice for fifteen medical colleges in New Zealand who support medical practitioners working in 36 specialties. Through its members, CMC aims to improve, protect and promote public health via a well-trained medical workforce to serve the best interests of the New Zealand community.

Members of the CMC have reviewed NEAC's ethical framework, and feedback is set out below. Note that several individual colleges will also respond to the NEAC consultation directly.

1. Overall support for the framework

Members of the CMC commend NEAC for developing this ethical framework in response to the COVID-19 pandemic, with the aim of helping health professionals, managers and policy makers make decisions about prioritising and distributing resources in times of scarcity. The framework should be a useful resource for guiding discussions and debate about resource allocation during the COVID-19 pandemic, and recognising ethical tensions that need to be navigated in times of resource scarcity.

The CMC also commends the framework's reference to Te Tiriti o Waitangi, and the principles of Te Tiriti as articulated by the Waitangi Tribunal and the Courts: guarantee of tino rangatiratanga; the principle of options; active protection; and partnership. In general, table two in the document sets out useful examples of how the principles of Te Tiriti apply to resource allocation.

2. Scope of the document

The consultation document suggests that the framework is intended to be developed further to apply more generally to pandemic situations. However, the title of the document suggests it is about resource allocation in times of scarcity.

It would be beneficial to further clarify the title, scope and purpose of the framework document, to specify clearly whether the framework is limited to prioritisation decisions in a pandemic, or extends to prioritisation in times of resource scarcity more generally.

Resource scarcity and prioritisation is a constant challenge faced by the health sector, and is not limited to pandemic situations. If the NEAC's framework document is limited to pandemic situations, it would be useful to provide further context about why decision-making for resource allocation in a pandemic situation will differ to decision-making and resource allocation in non-pandemic scenarios where resource scarcity is a factor.

3. Decision making groups

NEAC has recommended that decision-making groups are set up in health service institutions at both the national and local level to support decisions around allocation of resources; and to separate care and advocacy for the patient from the allocation decisions.

Feedback on this proposal is varied. The Royal Australasian College of Obstetricians and Gynaecologists (RANZCOG) notes in its submission that the proposal for decision making groups is wise, and the Australasian College for Emergency Medicine (ACEM) suggests the groups should be mandatory. RANZCOG notes however, that there will be aspects of decision making that can only be made with detailed understanding of the clinical circumstances. Similarly, the Australian and New Zealand College of Anaesthetists (ANZCA) highlights that although the proposal for an independent decision making group is understandable, it must be balanced as removing specialist involvement in the decision-making process could create a disconnect to the values set out in the framework document, and result in poorer patient outcomes.

The composition of decision-making groups also raised concerns for colleges. The Royal Australasian College of Physicians (RACP) highlighted that small health

services would likely struggle to have decision making groups that include Māori, disabled people, clinicians, ethicists, legal, and community stakeholders, due to sheer size. Also, ANZCA highlights that the wording to "consider" representative group membership is not direct enough, and allows for diverse membership of groups to be "considered" but not acted-upon.

The CMC recommends that the framework provide further advice about how decision making groups can best achieve representative decision-making, bearing in mind the different capacity for groups across the country.

4. Considering equity in resource allocation

The CMC has significant concerns that the framework does not provide sufficient guidance on how to achieve equity in resource allocation in times of resource scarcity. This concern was raised by several colleges. It was noted that the framework does a good job of highlighting ethical tensions between equity and utility, but does not offer guidance with how to navigate these tensions.

The RACP states that this approach will not achieve Māori health equity. Decision-making will likely continue to hinge on purely clinical considerations rather than taking equity into account, and entrenched systemic inequities will be perpetuated. The RACP also highlights that problems with inherent bias and racism within the health sector necessitate a clear framework for navigating ethical concerns.

Similarly, ACEM highlighted concerns from clinicians that triage plans proposed in DHBs during the pandemic would have disadvantaged Māori and exacerbated inequity. ACEM states more support is needed to assist clinicians to apply Te Tiriti principles when making decisions on resource allocation. RANZCOG's submission also notes that more detailed guidance in achieving equity is needed, and input should be sought from Māori health groups and iwi.

ANZCA's submission recommends that to support equitable allocation of resources, it would be useful for the framework to mention that sometimes a larger ratio of allocation to vulnerable versus low-risk groups may be needed.

Overall, the CMC considers further work is needed on the framework to support navigating the tensions between utility and equity when allocating resource, and to ensure that health inequity for Māori and other marginalised groups is not perpetuated. The CMC recommends that NEAC engage with Māori health groups such as Te Rōpū Whakakaupapa Urutā to seek further review of the framework.

5. Prioritising PPE for healthcare workers

The document discusses the example that healthcare workers may be prioritised for PPE due to their greater risk of contracting COVID-19 due to the nature of their work. The CMC suggests another key factor for prioritising PPE for healthcare workers should be mentioned – that healthcare workers risk becoming vectors for the disease and spreading it to vulnerable patients. The same argument applies to vaccines. PPE and vaccines for healthcare workers have wider population health benefits of preventing spread among vulnerable groups coming in contact with health services.

The CMC also recommends that legislative requirements for PPE provision to enable a safe workplace under the Health and Safety at Work Act 2015 are referenced in this example.

6. Examples of public health resources

The CMC recommends that the examples of public health resources under the allocation of resources section is reviewed. Factors such as access to educational resources and information should be included. Access to measures such as robust contact tracing; appropriate isolation guidance and facilities; and surveillance testing in communities, may also be relevant.

7. Learnings from CMC's Choosing Wisely campaign

The CMC has facilitated the Choosing Wisely campaign in New Zealand. Choosing Wisely is an international campaign that promotes a culture where low value and inappropriate clinical interventions are avoided, and patients and health professionals have well-informed conversations around their treatment options, leading to better decisions and outcomes. The main purpose of Choosing Wisely is quality improvement. However, if implemented carefully, the principles of the campaign can assist with resource stewardship.

Particular care needs to be taken, however, in terms of health equity. A recent report commissioned by Te ORA and Choosing Wisely, *Choosing Wisely means Choosing Equity*, identified that messages focused only on reducing tests and treatments are problematic, and that health providers must deliver appropriate care and facilitate opening conversations with Māori patients that encourage shared-decision making, and ensure patients know they have the right to ask questions. Although not directly related to a pandemic situation, some of the principles of Choosing Wisely, and the *Choosing Wisely means Choosing Equity* report, are worth considering. Further information is available here: https://choosingwisely.org.nz/about-us/

Thank you once again for the opportunity to comment on the framework. If you have any questions or would like to discuss the CMC's submission further, please contact Virginia Mills (Executive Director) at virginia.mills@cmc.org.nz.

Nāku noa, nā

Dr John Bonning

Chair