EDITORIAL

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Ethics and equity in the time of Coronavirus

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'*He waka eke noa*. We're all in this together.' This is an advertising slogan from the New Zealand (NZ) government during lockdown. It implies that we all have been sharing, and will share, equal risks and burdens during this time of the coronavirus pandemic. Unfortunately, there are many ways this pandemic not only reveals but also amplifies the health inequities in society,[1] resulting in people already at risk of poor health outcomes carrying greater burdens and risks during these times. We are not all equally in this together. Our *waka* (canoe) has different sections, from steerage to first class.

Poverty is a known risk factor for death from coronavirus infection.[2] In NZ, as elsewhere, people with lower incomes were less able to physically isolate. While middle income workers retreated to make-shift home offices, people employed in essential but low paid work (such as rubbish collection, bus driving and cleaning) risked high levels of exposure to COVID-19.[3] As in other countries, this division of income also marks a division of ethnicity: in NZ proportionally more Māori and Pasifika are employed in the service sector and lower income jobs.[4] This could lead to higher rates of exposure and infection for these ethnic groups,[5] exacerbated by social issues such as poor and crowded housing,[6] if the pandemic had not been contained (as it probably has been in NZ,[7] at least at the time of writing this editorial). Similar disparities in exposure have also been seen in the United States of America,[8] and Britain,[9] showing that ethnicity is a risk factor for both contracting the disease and dying from it and that crisis planning rarely takes underlying inequities sufficiently into account.[10]

Culture is a profound yet often neglected determinant of seeking health care, the quality of healthcare patients receive and the treatment preferences of patients.[11] The NZ government has been criticised for lacking multicultural input into its construction of the measures taken to reduce the risks of COVID-19.[12] One outcome of this was Māori taking the initiative and protecting their own communities with safety-checkpoints. Risking being interpreted as vigilantism, these checkpoints discouraged unnecessary visitors to their communities, a strategy also used by other First Nations people.[13] From a Māori perspective such checkpoints were a legitimate expression of *manaakitanga* or taking care of others, in this case both themselves and the would-be visitors.[14] The checkpoints did provoke debate but the NZ Police Commissioner publicly supported these checkpoints, acknowledging their expression being culturally-appropriate Māori concern for others and an important safety measure.[15]

Other already-vulnerable groups have been adversely affected. Aged residential care patients represent the majority of COVID-19 deaths in NZ thus far.[16] The general public were not informed about treatment futility with respect to this group (as mechanical ventilation is inappropriate) and why the provision of adequate palliative care was prioritised below infection risk management.[17] Sadly, internationally and in NZ, lockdown measures resulted in patients with and without coronavirus dying without family members present, in possible violation of the Health and Disability Consumers Code of Rights.[18]

Time under lockdown has also been distressing for many migrant and refugee families, with particular concerns about access to information.[19] Similar issues affect other already-vulnerable groups, including the immunocompromised, homeless, migrant workers and beneficiaries. Additionally,

there are the newly vulnerable, the unexpectedly unemployed.[20] Predictions have been made of increasing friction between rich and poor, as well as significant rises in mental health disorders including post-traumatic stress disorder,[21] substance misuse and gambling.[22]

Rural communities can struggle to access healthcare even in normal times and there are long-standing inequities between rural and urban medicine which can be exacerbated in a pandemic.[23] The older average age of rural populations, less internet infrastructure and fewer healthcare options make rural communities more at risk from coronavirus than urban communities internationally.[24] Partly due to the publicly-funded rural hospitals here, NZ has been spared the collapse of rural healthcare that is occurring in America.[25]

Government responses and lockdowns, even done well, have also caused increased morbidity and mortality by a reduction in patients seeking treatment for non-COVID-19 conditions,[26] and the postponement of therapy such as surgery[27] and preventive screening.[28] This opportunity cost of the lockdown also includes the morbidity and mortality induced by unemployment and mental health issues. Whether these risks of lockdown are outweighed by the projected lives saved from dying of COVID-19 has still to be adequately analysed both here and overseas, but such analyses are essential in understanding the circumstances under which such measures are ethically justified.

Equity of information-provision has been problematic. There have been issues of access to digital information and telehealth, especially for people who are poor or homeless.[29] Understanding the risks, benefits and ethics of virtual healthcare is evolving concurrently with its widescale implementation.[30] There have been problems with too little information, for example, general practitioners not being directly informed by central testing stations of their patients' results in NZ (authors' personal experience) and overseas as well.[31] Conversely, there has also been a problem with an overload of information and a rush of papers appearing in journals and the media, without having undergone normal peer review. The 'noise' of this poor science makes it more difficult to know what to believe and undermines public health initiatives. In some cases the basic tenets of research ethics, in particular not upholding the principle that poor science is unethical and that scientific validity is a necessary condition of all research, has been cast aside in a feeding-frenzy of publication.[32] '*Caveat lector*'.[33]

Some have argued that ethically, this is a time for collectivism and collaboration rather than individualism, and for a global approach to the ethical issues faced in this pandemic.[34] Ethical decision-making under conditions of high uncertainty, such as in a pandemic, requires a close scrutiny of process.[35] Concerns have been raised about the ethics of triage protocols, especially in relationship to ethnicity,[36] disability[37] and obesity.[38] While restrictions on personal autonomy may be justified as a utilitarian necessity for the greater good of the population, the United Nations has expressed concern at the increased risks to human rights by authoritarian governments opportunistically increasing repression at this time.[39] Some sacrifice of usual ethical standards may be required but not complete abrogation.[40] This is of particular concern to Māori.[41] New aspects of ethics in times of pandemics, such as contact-tracing apps for longer term surveillance, are also concerning,[42] and may particularly impact adversely upon Māori.[43] More ethical analysis is needed.

Another aspect of this pandemic that has received some, but not enough, discussion are questions of the ethical responsibilities of doctors and other healthcare providers in situations where there is no personal protective equipment (PPE), not due to the health workers themselves, but because the government has failed to ensure its availability. There have been problems with the availability and distribution of PPE in NZ,[44] particularly for nurses, home care providers and rest home carers.[45] These healthcare providers may be less empowered to access PPE in healthcare hierarchies.[46] Is there an ethical obligation to treat the sick, risk illness, and potentially die when effective protection from disease transmission is unavailable due to factors beyond a health carer's control?[47] The Hippocratic Oath does not ask doctors (and, by extension, other health carers) to be martyrs. Even if adequate PPE is supplied, ethical issues remain: for example, the negative impact it has on the hearing-impaired healthcare workers and patients,[48] and the possible gender bias in available sizes.[49]

On the positive side, opportunities to address previous inequities arise even amidst a pandemic. Lockdowns reduced air pollution, at least temporarily, causing a reduction in deaths due to this cause, even potentially outnumbering deaths due to the virus itself in some regions.[50] Deaths due to road accidents have decreased in NZ[51] and elsewhere during lockdowns. The British government's naming of the 'Nightingale' hospitals sparked several movements to recognise and celebrate in a similar way other nurses in British history who had been generally forgotten.[52]

Some aspects of this pandemic are unique to this era, but many are not. Even the roles of contact tracing, self-isolation and physical distancing in the prevention of infectious diseases are not new: these were well described by the English physician John Hargarth in the 1790s (in this case in relationship to smallpox).[53] His plan to reduce mortality failed due to the poor being unable to isolate due to their poverty and needing to earn income (despite extra financial support), and the rich ceasing to participate when a certain degree of herd immunity reduced their self-interest in doing so. *Plus ça change, plus c'est la même chose*. It is interesting that the current focus of debate in NZ around the ethics of the pandemic is not the infringement of personal liberty or restrictions on autonomy as much as issues of social justice, the spread of risk and burden of compliance over a population in a fair and equitable manner. The current success of NZ having possibly eliminated the virus notwithstanding, we will need to continue to engage with these issues of ethics and equity to ensure the *waka* rides into more still waters.

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