

Nursing Praxis in New Zealand

Given that New Zealand endorses the individual's right to health, the issue of what constitutes appropriate health care to protect this right remains problematic. Since everything is not possible choices must be made. Recent media campaigns have highlighted two areas of perceived need. One is the development of a heart transplant facility within New Zealand, and the other is for widespread Hepatitis B immunization. This paper provides a framework for examining some of the decisions Government must face if its health care policies are to be consistent with WHO statements and if it is to honour New Zealand's treaty obligations.

THE RIGHT TO HEALTH OR THE RIGHT TO HEALTH CARE

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Historically, and in contrast to the early introduction of a number of other rights, the right to health has been one of the last to be proclaimed. There are no references to the right to health in 18th and 19th century constitutions whereas a number of other rights are specifically mentioned.

It was, however, implicit in the post-World War II initiatives such as the Charter of the United Nations, signed at San Francisco on 26 June 1945. In its Preamble, the Charter stated *We, the peoples of the United Nations determined . . . to promote social progress and better standards of life in larger freedom, . . . have resolved to combine our efforts to accomplish these aims.*

The Universal Declaration of Human Rights which grew out of this Charter and was adopted on 10 December 1948, is a common standard of achievement for all peoples and all nations, an ideal rather than a legally binding set of rules. The United Nations then took the next step, of transforming the principles into treaty provisions which did establish legal obligations on each ratifying State as to how it would treat its own citizens.

Of the subsequent instruments, two are particularly relevant for my purpose here.

The first is the International Covenant on Civil and Political Rights which restrains the State from interfering in the citizen's right to vote, to

freedom of speech, etc. Article 7, for example, reads

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

It is these rights and freedoms against the State which make up the present proposal for a Bill of Rights in this country.¹

The second, the International Covenant on Economic, Social, and Cultural Rights² is quite different. In its Preamble it recognises *that the individual, having duties to other individuals and to the community in which he belongs, is under a responsibility to strive for the promotion and observance of the rights . . . in the . . . Covenant.*

Article 12 then states

1. *The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
2. *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
 - (a) *the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
 - (b) *the improvement of all aspects of environmental and industrial hygiene;*

- (c) *the prevention, treatment, and control of epidemic, endemic, occupational and other diseases;*
- (d) *the creation of conditions which would assure to all medical service and medical attention in the event of sickness.*

New Zealand ratified both in November 1978, thus committing itself to international sanctions should it fail to comply.

The Preamble to the WHO Constitution also affirms that it is one of the fundamental rights of every human being to enjoy "the highest attainable standard of health" and that "governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures".

Adopted by the World Health Assembly in 1970, Resolution WHA 23.41(8) went far beyond these provisions in declaring without qualification that "the right to health is a fundamental human right".

At the same time, another resolution, WHA 23.61(9), stated that "the attainment by all peoples of the highest possible level of health" is the main long-term objective of the WHO and that the most important condition for this is the development of efficient national health systems in all countries.

The important thing to notice about all these statements is the emphasis on everyone and the use of relative measures such as "attainable". They do not require guaranteed access to all the miracles of medical science but rather access to what is available according to the resources and capacity of the country ratifying the instrument.

The balance of Article 12 of the Covenant on Economic, Social, and Cultural Rights is worth noting. While requiring the State to take steps necessary for a variety of public health measures ranging from child health to epidemic control, it leaves it open for individual States to "create conditions which assure to *all* medical service and medical attention in the event of sickness" (my emphasis).

The actual decisions about the allocation of resources are left up to the individual State.

Provided sufficient money is available for public health purposes, there is no direction as to the level of medical services provided short of requiring that what there is should be available to all *without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.* (Article 22).

Who then is to determine what that level is to be?

Community participation has become a popular catchcry. Like so many catchcries, it means different things to different people.

A recent study in the Americas³ found that most health system planners and administrators in the countries studied tended to regard community participation as a way of helping the health system deliver services to the community instead of seeing it as a process enabling the community to solve its own problems in its own way with the health system's assistance and support.

The New Zealand public has good reason to feel totally confused and even angry about the way in which health care issues have confronted them over recent times. Even a cursory glance over local newspapers would reveal the ongoing saga of heart transplants with headlines such as "the politics of the heart"⁴ "hearts on 'private' ruled out"⁵ "shattered heart patient speaks"⁶ as well as regular references to other medical advances such as liver transplants and the new birth technologies, coupled with predictions of epidemics — AIDS, Hepatitis B, and now a "new virulent form of cervical cancer".⁷ Perhaps even more disturbing has been the extensive media exposure of medical specialists "Surgeon calls for heart swaps in NZ", "Heart doctor calls for \$2m"⁸, "[X]'s doctor eyes private transplant"⁹, and "hospital frailty disturbs specialist".¹⁰

Traditionally it has been the doctor who has the trust of people and the doctor-patient relationship established under the Hippocratic Oath requires that the doctor should do whatever is necessary for the patient's wellbeing.

The question must be, how is a balance to be achieved between the needs of all those who may be seeking care, given that each doctor is committed to the maximum possible for each in-

dividual patient. This commitment to the Hippocratic principle makes it impossible for doctors to address the allocation of scant resources with the inevitable consequence that some may miss out.

Can they be required to choose between even two individuals, both of whom stand in that very special relationship?

Furthermore, a Hippocratic rule approach results in the aggregation of thousands of individual decision-making units, each with its own set of preferences and constraints rather than from a coherent process of determining needs and setting priorities.

Just over a year ago, a similar media campaign was being waged about the dramatic increase in incidence of Hepatitis B, especially in the East Coast of New Zealand. Similar headlines about the threat to life, the vulnerability of children to this disease, and the long term effects of the illness, were in newspapers throughout the country. Experts expounded on the need for vaccination. Private funds were being raised where public monies were not being made available.

What do heart transplants and vaccination against Hepatitis B have in common?

Both are the result of intensive medical and scientific research, particularly in the field of immunology. Both depend on work by highly specialised teams. Both save lives. Both cost money. Both are seen as health care. The setting up of a program providing either heart transplants or vaccination against Hepatitis B could be considered a health service issue.

The perfecting of the heart transplant procedure and the development of the vaccine are examples of the enormous advances made in the treatment of disease in response to ever-rising expectations of prolonged life and health.

Decisions about lives are always overlaid with ideology and symbolism. It is difficult for a democratic government, especially with New Zealand's welfare state tradition, to assume responsibility for refusing to help somebody whom it is perceived as being obliged to assist. The societal notion that life is priceless may be comforting but on closer analysis, can easily be shown to be a myth. People risk life and health for

a variety of reasons from economic survival to leisure time excitement. Yet when government as the representative of society, focuses on the life or health of a single person under its wing, it feels obliged to act in accordance with the myth. Indeed, in such circumstances, governments resist munificence only at their peril.

The escalating cost of the aggregation of individual decisions within the health system makes it imperative that science address the urgent need for information about the link between health status and health services.

The relationship between science and society is never constant. We see many ways in which not only is society changing but also science is changing with new directions and new emphases. It is seeking new ways to provide information on which decisions can be made, on which choices can be made about the future. As Jacob Bronowski reminded us, it is a special feature of the human mind to be able to set up artificial futures and decide to plan towards one rather than another.¹¹ It is the duty of science to provide the best possible information on which these projections can be made.

The public health sciences are concerned with the management, prevention, and control of diseases and other health problems in the community. Their focus is populations and groups rather than individuals. Epidemiology stands in the centre of the public health sciences, identifying the determinants of health problems as well as seeking measures to control or prevent the occurrence of illness in human populations.

Like so many words, "epidemiology" has changed its meaning over the years. It is not mentioned in Samuel Johnson's Dictionary of the English Language although, not surprising in 1775, epidemic "that which plagues" is mentioned. Its original use was to "describe that branch of medical science which treats of epidemics"; but it came to be understood as "a science that deals with incidence, distribution, and control of disease in a population whether or not the disease in question is epidemic or communicable".¹²

A more recent modification of the term has come to include the critical evaluation of mea-

Nursing Praxis in New Zealand

asures directed at treatment of disease as well as its prevention (and therefore by implication, the study of prognosis).

The models of social impact assessment being used by the Town and Country Planning Directorate of the Ministry of Works and Development¹³ are examples of the application of what are essentially epidemiological methods in a special area of prognosis — studying and predicting the impact on communities of social changes and development including the current State Services restructuring.

Others are making considerable progress in the second area, critical evaluation. There has been a steady progression from end point measurement (i.e. deaths) through process measurement (bed days, notification of diseases) to outcome measurement (quality of life adjusted years). The latter involves actually asking people how they have benefitted or how the quality of their life has changed following some major medical intervention. Foremost is the work being done by Professor Alan Williams and his team who are developing a quality adjusted life years-cost index which combines quality of life measures, survival rates, and resource input.¹⁴

This should make it possible for the community to compare a range of health care procedures and hence programmes, not just in quantitative terms but also in qualitative terms. It will also provide consumer input into what has hitherto been a technological process. But it will have to take into account the beliefs, values, and aspirations of each particular community. British tools could not be used here without regard for our New Zealand value system.

What would happen if we were to look at my two earlier examples — heart transplant and Hepatitis B vaccination programmes in the light of the preceding discussion?

One further feature these have in common is that each has been the subject of a special report so that, unlike many other controversial issues, an effort has been made to systematically collect information from both scientific and community sources.

The first, took the form of a report to the Minister of Health on the Eastern Bay of Plenty Hepatitis B Immunisation Programme by Professor Eru Pomare of the Wellington School of Medicine in November 1985.¹⁵ He saw an urgent need for the Health Department to extend its current programme of immunising children of carrier mothers at birth to cover all those at high risk, particularly children in areas where there are proportionately more Maori. He estimated that if only North Island preschoolers were vaccinated and the new yeast derived vaccine were available, approximately \$1.6 million would be needed. He also commented that cheaper vaccines were on the horizon but that the programme should not be delayed waiting for them.

The second was the report of the Cardiac Surgical Services Review Committee of the Hospitals Advisory Council, chaired by Mr Henry Lang, former Secretary to the Treasury, on 16 December 1986.¹⁶ Its brief was to investigate and report on the present state of cardiac surgical services in New Zealand provided in both public and private sectors.

The Lang report set the cost of heart transplants at \$24,000 or the equivalent of two coronary bypass procedures. Furthermore, they observed

the actual heart transplant imposes ongoing maintenance costs of \$20,000 for the first year of survival and \$18,000 per year thereafter . . . About 50% of heart transplant patients are alive eight years after their operation . . . on average, it provides good quality of life for eight to ten years.

Their estimate of the cost of a heart transplant programme of 12 heart transplants a year is \$1 million by year five.

In November, 1986, the Minister of Health announced the availability of funds for three years for a selective Hepatitis B campaign. This was to be in addition to the existing programme for vaccinating at risk newborns throughout the country whose mothers had shown positive Hepatitis B surface antigen results. The sum of \$1 million available to vaccinate all newborns in the six selected high risk areas would be very close to that required to finance the suggested heart transplant programme.

Data about the incidence of cirrhosis of the liver directly attributable to Hepatitis B is unreliable because of the frequent association of the condition with alcoholism. Hepatitis B is certainly a common cause of morbidity and mortality in New Zealand. Chronic carriage of Hepatitis B has been shown to be causally associated with the development of primary hepatoma (a liver cancer). Presently 50 new cases/year are recorded in New Zealand. It would be safe to assume that at least one case of primary hepatoma will be averted per year by the vaccination programme.

Science, in this case, public health science, has been used to shed light on two highly emotive issues requiring the allocation of public monies. But it has not made the decision. That decision must be a political one. Health is a political affair. The allocation of public money whether to Vote Health or to individual hospital or area health boards is a political affair.

Science, in the form of medical science has placed artificial barriers on the health field. Health has been equated with hospitals, hospitals with sophisticated and expensive technology. Health improvements are seen to occur only as the result of medical and technological interventions.

I believe that there are two different approaches to the relationship of the right to health and the right to health care. There is one which maintains that those who provide the interventions can control the outcome, that more health care (as defined by health professionals) will improve health. The other maintains that the control of interventions lies in the hands of those who use or should be able to use the interventions, but assumes that the means by which this choice is made is, or can be, exercised depends on factors over which they have little control.

These factors are the social, political and economic conditions of individuals and populations to which professionals contribute but do not define. These are public policy choices.

There is an urgent need for science to address the link between health status and the health services. But efficacy alone is not enough. The examples I have used today have been raised as

relatively isolated problems of resource allocation and financing in response to a very specific kind of political pressure. Many public policy choices are posed in this way — though not all are. There are occasions or periods when more systematic features of institutions are open to revision and reform.

I began by a consideration of the international human rights initiatives which followed World War II. New Zealand saw a similar major reform in 1938 following the depression. The Royal Commission on Social Policy seeks to initiate discussion of how to make the New Zealand society of today more just.

I have considered rights to health care from two different perspectives, using recent health issues to illustrate how science or rational approaches might be used to assess medical advances. The programmes outlined will each require about \$1 million dollars of tax money per year. One will benefit almost 20,000 people, newborns with a full life expectancy ahead of them. One will benefit 12 people per year. Each of these people could enjoy eight to ten additional years of a fair quality life.

One falls within New Zealand's international obligations. One is dependent on the priority given to specific interventions once these international human rights obligations have been fulfilled.

I have sought to indicate how science, in this case, the public health sciences, is constantly seeking new ways of serving society. Perhaps I should end with a quote from C P Snow — not from his famous "The Two Cultures" but from "Science and Government".

So far as I have been able to observe anything, this is how the world ticks — not only our world, but also the future world one can imagine, juster, and more sensible than ours. It seems to me important that (people) of good will should make an effort to understand how the world ticks; it is the only way to make it tick better.

. . . Is there any way, in this great domain of science and government, . . . we can arrange to make these choices a little more reasonably?²¹⁷

REFERENCES

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