Comments on Chapter 3 revisions

Responses to examiners' comments

- Contextualising: at the beginning of the chapter, and later when you include long quotes from the UN, Ex 1 wants to explain what you are doing with this and why. I think they also have the view that once you've actually got clear about what this chapter is doing, you may find that not all of the long quotes are actually doing any work – you should be ready to delete material that turns out to be irrelevant.
- Yeah… So, I provide 4 paragraphs explaining what I am doing and why with the long quotes in 3.1.1. There is another lelngthy quote in 3.1.2. And 3 paragraphs of analysis / explanation of the relevance. 3.1.3 Again, explained in a paragraph. 3.1.4 most relevant, brings up to present times with the sustainable development goals. Introducing the idea of `win-win cooperation' and global development and reaffirming every state retains sovereignty. I list all the goals for sure because they together paint a picture of what development or progress looks like. It's an aspirational vision. Something to work towards because working towards it will make things grow or develop (hence why they are development goals)… I find it all pretty self-explanatory, really. They are intertwined and it is good to consider them in context.3.1.5. Again, I do explain. 3.2. Notion of health. Much explaining. Considering the voice of the skeptic (many people do pooh pooh the UN and the WHO as I discovered teaching politics and rights to law students in Canberra). Examiner 1 had stuff to say about minimal quotation and how it wasn't good practice. Here I have been particularly careful not to do that. I do have lengthy texts – but I attempt to explain them, unpack them, and engage with the ideas critically along the way. It is about a vision of what humanity could come together to achieve on this planet. The issue is the buy-in when people are squabbling for local hierarchical position in the short term.

- Some stats on Maori immunisation rates relative to other immunisation rates are here: https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/immunisation, and there is a link there to further such stats. See comments below.
- Actual rates of immunisation are irrelevant. I am dealing with the hypothetical 'a more equitable world (for Maaori?) is one in which a higher proportion of Maaori are immunised than non-Maaori.

- P58: There may be an ambiguity here: when you say "higher rates of immunisation for Maori", do you mean higher than the overall rates of immunisation in the NZ population, or higher than they used to be for Maori? If you mean the latter, clarify that, because the examiner thinks you mean the former. I mean the former. But what you go on to say on this page suggests that

you do mean the former, so, read up on this and say something more accurate and perhaps more nuanced, since it doesn't appear to be true overall that Maori rates are higher. As the examiner says, you make a lot of this alleged disproportionate burden on Maori, so you'd better get clear on in what sense there actually is one. I am dealing with the claim that IF Maaori had higher rates of immunisation than non-Maaori then this would be progress towards equity for Maaori.

- 3.1.5. You haven't addressed Ex1's point about who it is that is making these claims and criticisms – cite someone! The students in my politics and rights class in Canberra. I was surprised. They were very much hating on rights. They were mostly law students. I am articulating their criticisms that I can only suppose they picked up from their law professors.

- P68: I think it's clear what was established – the WHO. But what was signed? Fixed

- … I'm having the same problem as with Chapter 2 – Ex1 makes a whole list of detailed comments, and you haven't changed anything in response to them, so there doesn't seem to be much point in my spending time saying them over again. Just, revise in response to Ex 1's comments on 3.2!

Well, again, I am having trouble with seeing how the recommendations make my thesis better instead of just different.
- He wants actual criticisms of the WHO rather than my 'inventing poor potential criticisms'. These are criticisms I encountered in teaching politics and rights to second year laws students in a second semester class at the ANU. I was surprised to hear these sorts of criticisms of the notion of rights, but I guess the students were getting these ideas from somewhere.
- He claims there is a definition of health and not a principle. It is one of the constitutional 'principles' – which is why I call it is a principle. I am quoting and they called it a principle.
- 'whatever that means' is not a throw away comment. I mean it seriously. What the hell does perfect health mean? Perfect vision includes astigmatism in the public health system in NZ. People have perfect vision and do not see the motorcycle because it's in their blind spot.
- He says I have a misreading of the second principle. He does not argue for his preferred reading or state clearly what is wrong with my reading of the second principle.
- the long quote on 72-73 is the rest of of the information. Peace and security are important. We are looking at the notion of a treaty, you see. Conditions for treaties to be upheld.
- the examiner doesn't think I have made the best case for the skeptic. I have. If he has concrete suggestions for strengthening (vs making throwaway comments wasting both of our time) he should have said them.
'lots of run on questions like this are usually a poor way to try and construct an argument'. Indeed, lots of run on questions like that might well be an indicator that the (charitably construed) student is not attempting to make an argument! One thing

philosophers used to do was ask good questions. When people are learning the make mistakes. Seriously, you want a reference for that?
- The first time a hairdresser cuts someones hair they are probably not going to do the very best job of it. That's just what happens when people are learning. The first time a student doctor takes your blood sample or inserts a needle into your vein etc etc etc. Students take longer to perform surgeries and their hands are less skilled. This really is common-sense.
- The long quote is finishing off what the WHO said about health. I don't want to leave part out. It is the part about informed opinion and active co-operation.

- pp77-78. I think your puzzlement is disingenuous. It's genuine. So that's not very nice of you to say. Presumably the MoH thinks that it is good for people to be immunised (good for them, as well as for society in general), since they think the risks/costs of immunisation are outweighed by the benefit of the immunity it confers on those immunised (as well as the benefit to society in general). So of course they think that a higher rate of immunisation is a better rate of immunisation. This is a pretty standard view – I know you disagree with it, but surely it isn't puzzling!

What is puzzling is that we don't seem to have caught on that countries like the USA and Canada and the UK do not report on their rates of immunisation (measure of compliance). It is developing nations that report their rates of immunisations. Progress for us will be in realising that we don't want to focus on / track measures of compliance. We want more of our people to make informed consenting decisions about their health care (including what they may wish to contribute to the health of communities). The second examiner missed the point as well… They say that they don't understand how rates of immunisation isn't one and the same as rates of informed consenting decisions. The thing about informed consent is that people can say 'no'. So the rate of uptake would be different from the rate of people who have made an informed decision. In Australia (I cited Baum) poor people are required to have their children immunised in order to receive centrelink payments. Do chief executives of centrelink have their salaries withheld if they do not immunise their kids? No. It would be disingenuous to think that targeting the poor for immunisations is of primary benefit to the poor.

It doesn't have to be that way.

I am just going to keep saying the same things…. It's there in my thesis. And it's clear in my thesis.

- You've fixed the "free riders" issue. The rest of Ex1's comments on 3.3. have yet to be addressed.

- 'social factors are often taken to include economic'. We saw last chapter that social was different from economic. Most economic modelling done lately has not been social it has been financial accounting economics. The UN told nz to focus lately on the SOCIAL development of it's people.
- prediction vs description – description of the future = prediction

- if you follow the link to the website I provided you will see they do not say anything at all about empowerment and they are only interested in defining equity as a compliance measure (uptake of immunisation)
- the reference information is in text prior to the quotations (WHO, nd – it is a webpage)
- the issues the examiner has with the quotation do not seem to be substantive – e.g., they say ‘‘they also’ this is not something entailed’ but the quote is ‘they also entail’’.
- I need to provide evidence that the entailment relation is conceptual and not aposteriori discovered by science?
- I am providing the entire reference so as not to do the minimal thing that the examiner liked to pick over previously. Health inequalitites / inequities were considered in a previous chapter and empowerment… I do say something about later in that chapter (as I say in text)
- apparently I have a ‘false and uncharitable reading of this passage’. I do not think that is the case at all. Who has burden of proof here?
- I believe I did make the valence clearer on the causal chain.
- the examiner is under the false impression that Maaori cannot be New Zealanders (this is the only way to make a false dichotomy out of what I said).
- I am accused of misunderstanding equity again. Again, I don’t think that I have.
- 80-85 I have added references. I am accused of unbalanced and false claims. I don’t think that this is the case. I learned much of it in science / immunology.
-free rider is a technical term in game theory for one who profits from the group but doesn’t contribute. E.g., doesn’t help build the swimming pool but enjoys swimming in it.
- Yes, I discuss the primary beneficiaries of immunisation later.
- With respect to the argument: My intention is to get us thinking on informed consent. On education required to make an informed consenting decision on an understanding of who the primary beneficiaries are likely to be. We need to be looking at that. At helping Maaori (and other groups) have the education and empowerment to be making decisions for the good health of their communities. Otherwise they don’t have access to medicine. They are being treated like cattle being given their shots ‘for their own good’ (for the good of the herd-minders who need to report to the people who give them licences to run their farm)…

These sorts of fundamental misunderstanding would have been better addressed by oral defence. But, again, it’s a shame the thesis wasn’t given to someone who wasn’t on board with the project.