

HAUMARU

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The COVID-19 Priority Report

WAI 2575

WAITANGI TRIBUNAL REPORT 2023



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*‘Inaa tere ngaa kapua, he hau kei muri?
Kaupapa hau-tupua! Kaupapa hau-ora! Kaupapa hau-maru!
Whakataka ana te hau o te muri!
Whakataka ana te hau o te tonga!
E maakinakina ana aa-uta –
E maataratara ana aa-tai.
Kia tuu te toki nui, te toki roa, te toki taa wahie;
Kia hanatu au ki a Rangi e tuu iho nei
Kia hinga te moorearea, kia mate
Ki a Papatuuuanuku e takoto nei.
E ue, ue – nuku!
E ue, ue rangi!
Tee tuungia te kawaruu raa
Ko te hau tonga
Ka maranga mai raa
Tihee mauri ora!*

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Waitangi Tribunal
Te Rōpū Whakamana i te Tiriti o Waitangi
Kia puta ki te whai ao, ki te mārama

The Honourable Christopher Hipkins
Minister for COVID-19 Response

The Honourable Kelvin Davis
Minister for Māori Crown Relations: Te Arawhiti

The Honourable Willie Jackson
Minister for Māori Development

Parliament Buildings
WELLINGTON

20 December 2021

E ngaa Minita, teenaa koutou.

Noo maatou te mauri manahau ki te tuku atu i taa maatou puurongo, *Haumaru*, e paa ana ki te mate korona. E rua ngaa paatai kua whaarikihia kei mua i a maatou moo teenei take. Anei raa taa maatou whakahoki, hei maatakitaki maa te Kawanatanga, maa ngaa kaituku kereeme me te marea o Aotearoa nei hoki. E ai ki ngaa tikanga o raatou maa, me mihi ki ngaa mate o te waa nei, me kii raatou kua hinga, kua waahie e te toki nei, te mate urutaa nei, araa te mate korona. Hoki mai ki a taatou ngaa kanohi ora. Mauriora!

Introduction and scope of our inquiry

We are in unprecedented times. The COVID-19 pandemic has caused significant disruption. It has prompted the most challenging public health response ever seen in this country. It has called for a multi-faceted Crown response, requiring vast public resources and expenditure. It has literally changed the way we live.

We were asked by the claimants on behalf of the New Zealand Māori Council to inquire into aspects of the Crown's response to the COVID-19 pandemic. On 23 November 2021, we decided to hold a priority hearing,

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in the context of the Health Services and Outcomes Kaupapa Inquiry, into two of those aspects: the Crown's COVID-19 vaccination strategy and the move to the COVID-19 Protection Framework (referred to as the 'traffic light system'). Our priority hearing was held from 6 to 10 December 2021.

We identified the following specific issues for our inquiry:

1. Having regard to the disproportionate numbers of Maaori vaccination rates and COVID-19 cases:
 - (a) Is the Crown's vaccination strategy and plan consistent with te Tiriti o Waitangi and its principles?
 - (b) Is the Crown's November 2021 COVID-19 Protection Framework consistent with te Tiriti o Waitangi and its principles?
2. What changes are required to ensure the Crown's vaccination strategy and November 2021 covid-19 Protection Framework are Tiriti compliant?

Our report

We enclose our report on these issues, *Haumaruru*.

Although our report has been produced relatively quickly, we have benefited significantly from our previous report on the health system, *Hauora*. In that report we set out the Tiriti principles that are engaged by the health system generally. The evidence before us shows that, in responding to the pandemic, the Crown has constantly reminded itself of these principles and the need to comply with them. We have therefore relied heavily on these principles for our inquiry.

The vaccination strategy

Once COVID-19 was effectively eliminated from Aotearoa New Zealand in 2020, focus turned to vaccination. The worldwide response to the pandemic included the rapid development of vaccines. Relevantly for our purposes, in March 2021 the Crown published the *COVID-19 Maaori Vaccine and Immunisation Plan*, outlining the key initiatives it would undertake to ensure that the Crown's broader vaccination programme addressed the principles of te Tiriti and supported Maaori health and equity.

Data

It is crucial, particularly in a pandemic, for the Crown to collect and maintain sufficient data to inform Crown policy and ensure an effective vaccine rollout. In our stage one report, *Hauora*, we recommended that the Crown improve its collection of quantitative and qualitative ethnicity data and information relevant to Maaori health outcomes. Crown officials

who gave evidence in our inquiry acknowledged that the Crown still does not collect this data sufficiently. We have therefore found that the Crown does not collect sufficient data to accurately and equitably inform the rollout of the vaccine for Maaori, particularly taangata whaikaha. This failure is in breach of the Treaty principles of active protection and equity.

The age-based adjustment to the sequential vaccine rollout

In the early stages of the vaccine rollout, the vaccine itself was in limited supply. The Crown was required to prioritise how the vaccine should be delivered and focused on the most at-risk groups. Age was adopted as one aspect of the prioritisation, so that older persons would be eligible to receive the vaccine sooner. This prioritisation was a necessary response to limited vaccine supply.

The Crown understood that an age-based priority would disadvantage Maaori. That is because the Maaori population is much younger and on average Maaori do not live as long as the general population. The Crown received advice from the Ministry of Health, as well as from officials and experts, that the vaccine strategy should include an age adjustment for Maaori to account, in part, for these population demographics. This would mean Maaori would become eligible to receive the vaccine at a younger age. Cabinet declined to include this adjustment. Had the age adjustment been adopted, Maaori vaccination rates would have been higher when important Crown decisions were subsequently made.

Cabinet's decision to reject advice from its own officials to adopt an age adjustment for Maaori in the age-based vaccine rollout breached the Treaty principles of active protection and equity.

The COVID-19 Protection Framework

The second wave of COVID-19 infections occurred from August 2021, involving the Delta variant. After realising that the Delta variant would be difficult, if not impossible, to eliminate completely, the Crown moved to a 'minimise and protect' strategy. Among other things, this involved replacing the Alert Level Framework with the COVID-19 Protection Framework. Moving to this new approach was Treaty compliant.

However, issues arose because of the rapid transition to the new Protection Framework before vaccination rates for Maaori were commensurate with the general population. This has put Maaori, including Maaori health and whaanau ora providers, at risk. Accordingly, we have found that Cabinet's decision to transition to the Protection Framework on 15 December 2021, without the original district health board vaccination threshold:

- ▶ puts Maaori at disproportionate risk of Delta infection when compared with other population groups, in breach of the principles of active protection and equity;
- ▶ puts Maaori health and whaanau ora providers under extreme pressure and undermines their ability to provide equitable care for Maaori, in breach of the principles of tino rangatiratanga and options; and
- ▶ was made despite the strong, unanimous opposition of the Maaori health leaders and iwi leaders the Crown consulted, in breach of the principle of partnership.

Engagement with Maaori

A consistent theme emerged in our inquiry relating to the manner in which the Crown has engaged with Maaori during the pandemic, in particular the allegation that the Crown did not co-design the vaccine strategy or the Protection Framework with Maaori. We have found that:

- ▶ the Crown's failure to jointly design the vaccine sequencing framework breached the Treaty guarantee of tino rangatiratanga, and the principle of partnership; and
- ▶ the Crown did not consistently engage with Maaori to the fullest extent practicable on key decisions in its pandemic response. Further, the nature of its engagement was often one-sided, and as a result sometimes disrespectful. These omissions are in breach of the principle of partnership.

Prejudice to Maaori

In effect, the lack of adequate protection for Maaori afforded by the COVID-19 Protection Framework *is* the prejudice that has resulted from Cabinet's earlier decision to reject an age-adjusted vaccine rollout. As at 13 December 2021, although Maaori comprised 15.6 per cent of the population, Maaori comprised over 50 per cent of the Delta cases, 38.6 per cent of Delta hospitalisations, and 45 per cent of associated deaths. The statistics speak for themselves.

Our recommendations

To address the prejudice to Maaori resulting from the breaches outlined above, we have recommended that the Crown:

- ▶ urgently provide further funding, resourcing, data, and other support to assist Maaori providers and communities to address the various issues for Maaori arising from the pandemic;
- ▶ improve its collection of quantitative and qualitative ethnicity data and information relevant to Maaori health outcomes;

- ▶ prioritise the work to improve the quality of quantitative and qualitative data on taangata whaikaha and whaanau hauaa in partnership with Maaori disability care providers and community groups;
- ▶ strengthen its monitoring regime to enable it to identify, in as close to real time as possible, whether or not its policy settings in relation to Maaori are working as expected, so as to enable the Crown to change those settings to achieve the desired and intended results, and remain accountable to its Treaty partner;
- ▶ partner with Maaori to determine what elements of the pandemic response should be monitored and how that monitoring should be reported;
- ▶ partner with Maaori to design and implement an equitable paediatric and booster vaccine sequencing framework for Maaori, incorporating the expert advice offered in this inquiry; and
- ▶ engage with Maaori in accordance with specified, Treaty-based, principles.

Conclusion

We thank all of the parties, and their counsel, for their constructive approach to our inquiry. It would not have been possible to complete it in the required timeframe without their cooperation. We especially thank the witnesses who appeared before us, many of whom are at the coal face of this pandemic, working hard to protect our communities. E kore e mutu ngaa mihi ki a koutou.

We acknowledge the incredibly difficult circumstances that our communities have faced as a result of this pandemic. We also acknowledge the difficult and at times urgent decisions that the Crown has had to make. Maaori, and in particular the Maaori health providers and professionals at the front line of the pandemic response, have worked tirelessly to support their people in trying circumstances. It is an understatement to say much good work has been done, which we acknowledge fully. There is, however, work to do to ensure that the Crown's response to the pandemic is Treaty compliant and equitable for Maaori.



Judge Damian Hohepa Stone
Presiding Officer

ABBREVIATIONS

app	appendix
CVTAG	COVID-19 Vaccine Technical Advisory Group
DHB	district health board
doc	document
DPMC	Department of Prime Minister and Cabinet
ed	edition, editor, edited by
FTE	full-time equivalent
IHAG	Immunisation Implementation Advisory Group
ICU	intensive care unit
KWS	Ngaati Kahungunu ki Pooneke Community Services
ltd	limited
MIQ	managed isolation and quarantine
NHC	National Hauora Coalition
memo	memorandum
mrna	messenger ribonucleic acid
p, pp	page, pages
para	paragraph
PHO	primary health organisation
QR	quick response
s, ss	section, sections (of an Act of Parliament)
STAG	Science and Technical Advisory Group
vol	volume
Wai	Waitangi Tribunal claim

Unless otherwise stated, footnote references to briefs, claims, documents, memoranda, papers, submissions, and transcripts are to the Wai 2575 record of inquiry, a copy of the select index to which is reproduced in appendix III. A copy of the full index is available on request from the Waitangi Tribunal.

CHAPTER 1

INTRODUCTION TO THIS PRIORITY INQUIRY

1.1 THE PRIORITY INQUIRY

This report addresses a claim from the New Zealand Maaori Council concerning Crown policy for managing the COVID-19 pandemic.¹ Specifically, it addresses the Crown's vaccination strategy and rollout, and its development and implementation of the new COVID-19 Protection Framework (commonly referred to as the 'traffic light system'). The background to these two issues is detailed in chapter 2. In this chapter, we provide an overview of the procedural history of this inquiry.

1.2 THE INQUIRY PROCESS

The Health and Services Outcomes Kaupapa Inquiry (Wai 2575), has been conducted in stages. Stage one is complete and resulted in our report *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*.² Stage two is underway and phase one involves a prioritised inquiry into claims by or relating to taangata whaikaha, or Maaori with lived experience of disability. The first hearing for phase one of stage two of our inquiry was scheduled to be held on 6–10 December 2021.

On 15 November 2021, the Tribunal received a request from claimants on behalf of themselves and the New Zealand Maaori Council, to reallocate hearing one of this next stage of our inquiry.³ The proposed reallocation was to allow the Tribunal to instead hold a priority inquiry into aspects of the Crown's response to the COVID-19 pandemic. The Presiding Officer, Judge Damian Stone, directed the Crown, claimants, and interested parties deemed eligible to participate in either stage one or stage two of the Health Services and Outcomes Kaupapa Inquiry to file submissions by 19 November 2021 about whether such an inquiry should proceed.⁴ Judge Stone assured parties participating in phase one of stage two that, should the priority inquiry be granted, the phase one stage two inquiry would retain the same amount of hearing time that had already been allocated to it.⁵

1. Statement 1.1.3.

2. Stage one of the inquiry – which addressed the Crown's legislation, administration, funding, and monitoring of, the primary health care system in New Zealand – formally concluded when the Tribunal's 2019 report, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* was finalised in October 2021.

3. Memorandum 3.2.366

4. Memorandum 2.6.68, pp 3–4.

5. Ibid, p 5.

The Tribunal received 16 memoranda on behalf of 31 parties in response to this direction, which it took to indicate a significant level of interest in the request for a priority inquiry.⁶ As the application was for priority within an existing inquiry programme, the Tribunal only took account of submissions received from the 26 parties participating in the phase one, stage two, inquiry. Of those parties, 16 supported the proposed reallocation, five opposed it, and five neither supported nor opposed the reallocation.⁷

On the basis of these submissions, and conscious of the national significance of the matters raised by the New Zealand Maaori Council, the Tribunal determined it was appropriate to reallocate the December 2021 hearing to inquire into the Crown's response to the COVID-19 pandemic.⁸ The Tribunal determined the participation rights of various parties (the process used and the identities of the parties are outlined in 1.3 below) and stated its expectation that interested parties with full participation rights be actively involved in the design of the priority inquiry alongside the Crown and claimants.⁹

The Tribunal had previously adopted an accessibility protocol that would apply during phase one of stage two.¹⁰ This protocol was designed to provide generalised guidance and procedures to achieve an inquiry accessible to taangata whaikaha.¹¹ Given arrangements were already in place to enable taangata whaikaha to participate in what was to be hearing one of phase one of stage two, the Tribunal determined that it would comply with the accessibility protocol to the extent allowed by the tight timeframes of the priority inquiry.¹² This report has adopted, insofar as possible, sections of the accessibility protocol, such as releasing the report in unprotected Microsoft Word format, and using double vowels as opposed to tohutoo (macrons).

The hearing took place at the Waitangi Tribunal Unit's offices in Wellington between Monday 6 December and Friday 10 December 2021. In order to comply with COVID-19 related restrictions, parties were permitted to attend in person only when scheduled to present submissions, or to lead or cross-examine witnesses. Parties not attending in person were able to participate via Zoom video-conferencing.¹³

On the evening of 5 December 2021, which was the day before the hearing was set to begin, the Crown and the claimants filed a joint memorandum advising that they had already been in discussions aimed at addressing the concerns that were to be the subject of the priority inquiry.¹⁴ The next day, 6 December 2021, which

6. Memorandum 2.6.70, p 4.

7. Ibid.

8. Ibid, p 5.

9. Ibid, p 7.

10. Memorandum 2.6.59, p 2.

11. Memorandum 2.6.59(a), p 1.

12. Memorandum 2.6.70, p 9.

13. Memorandum 2.6.74, p 3.

14. Submission 3.2.441, p 1.

was the first day of hearing, the Tribunal's Registrar emailed parties, reiterating the Tribunal's expectation that all interested parties with full participation rights be actively involved in the design and prosecution of the priority inquiry. The email stated that the Tribunal had become aware during the first day of the hearing that the Crown and claimants had engaged in discussions and negotiations without involving interested parties with full participation rights. Judge Stone therefore granted leave for those interested parties to file amended statements of claim. The purpose of this invitation was to ensure that the priority inquiry could continue in the instance that the Crown and claimants reached agreement between themselves, and therefore concluded that the inquiry was no longer needed.¹⁵ After the hearing, and following assurances from claimant counsel that the discussions would not preclude the Tribunal from reporting and making recommendations, Judge Stone confirmed that the interested parties who filed amended statements of claims would not be registered as claimants for the purposes of the priority inquiry.¹⁶

Before the hearing started, the Crown filed an affidavit from the Minister of COVID-19 Response, the Honourable Chris Hipkins. The Crown advised that Minister Hipkins was unable to attend the hearing to present this evidence. Consequently, Judge Stone directed parties to file, in writing, any questions for Minister Hipkins. He also directed the Crown to file Minister Hipkins' responses to these questions, and to others posed by the Tribunal, shortly after the hearing concluded.¹⁷ Minister Hipkins' responses were received and considered by the Tribunal for the purposes of this report.

1.3 THE PARTIES

The application for a priority inquiry was made on behalf of four claimant groups. Of those four claims, only one had status within phase one of stage two of the Wai 2575 inquiry. Thus, leave was granted for a group comprising Archdeacon Harvey Ruru, George Ngatai, Ann Kendall, and Sir Edward Taihakurei Durie, on behalf of themselves and the New Zealand Maaori Council (Wai 2644), to participate in this inquiry as claimants. The other three were granted a watching brief.¹⁸

Other parties who indicated their desire to participate were allowed to do so as interested parties. Interested parties were granted participation rights based on their existing status, or lack thereof, in Wai 2575. The Tribunal also took account of their proximity to, or level of involvement in, implementing or responding to the Crown's response to the COVID-19 pandemic. Ultimately, the Tribunal determined the following interested parties met these criteria and they were therefore granted participation rights in this priority inquiry:

15. Memorandum 2.6.77, p 3.

16. *Ibid*, p 4.

17. *Ibid*, p 8.

18. Wai 2631, Wai 2632, and Wai 2640.

- ▶ Lady Tureiti Moxon on behalf of Te Koohao Health Limited, a Maaori health provider which is part of Whaanau Ora; Lady Moxon is chair of its parent body the National Urban Maaori Authority (Wai 2910).
- ▶ Rewiti Paraone, Kevin Prime, Erima Henare, Pita Tipene and Waihoroi Shortland on behalf of Te Runanga o Ngati Hine, representing the interests of the Ngati Hine Health Trust, a Maaori health provider in Te Tai Tokerau (Wai 682).
- ▶ Steven Wilson and Karen Pointon on behalf of Ngaati Turi (Maaori Deaf), the Te Roopu Waiora Trust, and Muauupoko Tribal Authority (Wai 2143).
- ▶ Henare Mason and Simon Tiwai Royal on behalf of the National Hauora Coalition (Wai 2687).
- ▶ Simon Tiwai Royal on behalf of the National Hauora Coalition (Wai 2943).
- ▶ Te Roopu Taurima O Manakau Trust (Te Roopu Taurima), for and on behalf of Te Roopu Taurima and for the benefit of those persons that Te Roopu Taurima support (Wai 2734).
- ▶ John Tamihere and Raymond Hall, on behalf of Te Whaanau o Waipareira Trust, the Manukau Urban Maaori Authority, the National Urban Maaori Authority, Te Roopu Awhina ki Porirua, and Kirikiriroa Marae (Wai 2720).
- ▶ Dr Rawiri Jansen and others on behalf of Te Ohu Rata o Aotearoa (Wai 2499).
- ▶ Trustees of Te Puna Ora o Mataatua (Wai 2912).¹⁹

These parties were granted leave to file submissions, evidence, proposed recommendations, and to cross-examine.

In addition, the following interested parties were granted the right to file evidence, which was taken as read:

- ▶ Robert Gabel on behalf of Ngaati Tara (Wai 1886).
- ▶ Tracy Hillier and Rita Wordsworth on behalf of Ngai Tamahaua hapuu (Wai 1781).
- ▶ Rosaria Hotere and the late Jane Hotere for and on behalf of themselves and their whaanau (Wai 2643).
- ▶ Dr Huhana Hickey on behalf of herself and other Maaori disabled (Wai 2619).
- ▶ David Ratu (Wai 2624).
- ▶ Donna Washbrook (Wai 2672).
- ▶ Bryar Te Hira on behalf of her whaanau (Wai 2476).
- ▶ Te Ruunanga o Ngaati Reehia (Wai 1341).
- ▶ Te Riwhi Whao Reti, Hau Hereora, Romana Tarau, Karen Herbert and Edward Cook on behalf of Te Kapotai (Wai 1464/Wai 1546).
- ▶ George Davies and Huhana Lyndon on behalf of descendants of Hairama Pita Kino (Wai 1544/Wai 1677).
- ▶ Maaka Tauranga Tibble for himself and on behalf of all Kapo Maaoro (Maaori blind, vision impaired, and deaf blind persons) and their whaanau and Kapo Maaori Aotearoa/New Zealand Incorporated (Wai 2109).

19. Memorandum 2.6.70(c).

- ▶ Te Karaka Clarke on behalf of Te Paatu hapu (Wai 1176).
- ▶ Robina Rihari concerning strokes and impacts on Maaori whaanau (Wai 2736).²⁰

Parties who had no existing status in the Wai 2575 inquiry and were granted a watching brief included:

- ▶ Dr Terence Lomax (Wai 605).
- ▶ Jane Mahingarangi Ruka Te Korako on behalf of the Grandmother Council of the Waitaha Nation (Wai 1940).
- ▶ Violet Walker on behalf of Tahawai (Wai 2382).
- ▶ Rangina Noke Wade for the members of Ngaati Waahiao and the Ngaati Waahiao Maaori Committee, Toro Bidois for the members of Te Arawa District Maaori Council, Wini Giddes for the members of Mataatua District Maaori Council, and Pieri Munro for the members of Tai Raawhiti District Maaori Council (Wai 2640).
- ▶ Kereama Pene for the members of Kia Maaia Ratana Committee of Oorakei and Wellsford Maaori Committee, Rob Aperahama and Dr Jo Diamond for the Auckland District Maaori Council, Pauline Vahakola Reweti and Warahi Paki for Tamaki ki Te Tonga District Maaori Council, and Kiriana Hakopa for the Waikato District Maaori Council (Wai 2632).
- ▶ John Hooker, Lynne Raumati, and Grace Hoet for themselves and for the members of the Aotea District Maaori Council (Wai 2631).
- ▶ Francis McLaughlin, on behalf of the Mongrel Mob, his whaanau, hapuu, iwi, whaanau whaanui, and whaangai; and Merepeka Raukawa-Tait, on behalf of her whaanau, hapuu, iwi, whaanau whaanui, and whaangai (Wai 2123).
- ▶ Kathleen Caldwell on behalf of the Ngaatiwai Trust Board and the iwi of Ngaatiwai.
- ▶ Dr Maria Baker on behalf of all Maaori (Wai 2723).
- ▶ Dame Aroha Reriti-Crofts on behalf of Te Ropu Wahine Maaori Toko i te Ora/the Maaori Women's Welfare League Inc (Wai 2959).
- ▶ Phillip Tauri King and Verna Tuteao for and on behalf of Ngaati Mahuta (Wai 1589).
- ▶ Te Runanga o Toa Rangatira and the Ora Toa Primary Health Organisation.²¹

1.4 THE ISSUES

This priority inquiry focuses on the following questions:

1. Having regard to the disproportionate numbers of Maaori vaccination rates and COVID-19 cases:
 - (a) Is the Crown's vaccination strategy and plan consistent with Te Tiriti o Waitangi and its principles?

20. Memorandum 2.6.70(d).

21. Memoranda 2.6.70(e), 2.6.75(b), 2.6.77.

1.5

- (b) Is the Crown's November 2021 COVID-19 Protection Framework consistent with Te Tiriti o Waitangi and its principles?
2. What changes are required to ensure the Crown's vaccination strategy and November 2021 COVID-19 Protection Framework are Tiriti compliant?²²

1.5 THE STRUCTURE OF THIS REPORT

In chapter 2, we discuss the background to this inquiry, including relevant timelines, decisions, and the legislative and policy context relating to the Crown's vaccination strategy and the COVID-19 Protection Framework.

In chapter 3, we identify and discuss the Crown's Treaty obligations that apply to this inquiry.

Our analysis and findings are presented in chapter 4, leading to the recommendations detailed in chapter 5.

22. Memorandum 2.6.70, p7.

CHAPTER 2

THE CONTEXT FOR THIS PRIORITY INQUIRY

2.1 INTRODUCTION

Aotearoa New Zealand recorded its first case of COVID-19 on 28 February 2020.¹ At the time of writing this report, the country has recorded 12,698 confirmed cases and 47 deaths.² The statement of facts agreed by all parties to this inquiry notes ‘COVID-19 poses a significant danger to life and can cause chronic debilitating illness.’³

This chapter provides further detail about the context within which this priority inquiry has taken place. It outlines:

- ▶ facts agreed by the parties to this inquiry;
- ▶ the legislative and policy context for the Crown’s vaccine rollout and pandemic response generally, including the COVID-19 Protection Framework;
- ▶ the funding distributed to assist Maaori with this response; and
- ▶ the positions of the parties.

Information in this chapter is largely based on Crown evidence and publicly available material. The chapter is intended to be neutral and descriptive, and should not be read as the Tribunal either endorsing or disapproving of any mechanisms, provisions, and decisions. A timeline of key decisions made by the Crown, following the arrival of COVID-19 in Aotearoa New Zealand in early 2020 is appended to this report as appendix 1.

2.2 COVID-19: THE AGREED FACTS GUIDING THIS INQUIRY

The Crown, claimants, and interested parties filed an agreed statement of facts to guide this inquiry.⁴ Its purpose was to outline issues that were uncontested. This statement included general factual information about COVID-19, relevant statistics for Maaori (relating to health, housing, poverty, rural populations, and tamariki), the vaccine and vaccinations, whaanau hauaa and taangata whaikaha, and the

1. Coronaviruses are a diverse family of viruses which cause illnesses such as the common cold. COVID-19 is caused by a coronavirus named sars-cov-2 that can affect your lungs, airways, and other organs: see ‘About Covid-19’, Ministry of Health, <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-health-advice-public/about-covid-19>, last modified 29 November 2021.

2. ‘New Zealand Situation’, World Health Organisation, <https://covid19.who.int/region/wpro/country/nz>, accessed 15 December 2021.

3. Submission 3.2.446, p 1.

4. Ibid, pp 1–7.

2.2.1

Delta outbreak insofar as it affects and relates to Maaori. Unless specifically referenced, all facts and figures included in this section come from the agreed statement of facts.⁵

2.2.1 COVID-19 generally

COVID-19 is an illness caused by the highly infectious SARS-COV-2 virus.

COVID-19 poses a significant danger to life and can cause chronic debilitating illness.

The elderly and people with pre-existing health conditions are at higher risk of more serious outcomes from a COVID-19 infection.

2.2.2 Relevant statistics for Maaori**2.2.2.1 Health statistics**

Maaori comprise approximately 16.5 per cent of the total population.

A greater proportion of Maaori than the general population have pre-existing health conditions of a kind that makes them susceptible to more severe COVID-19 outcomes. These pre-existing health conditions include (but are not necessarily limited to) chronic lung disease, cardiovascular disease, diabetes, immunodeficiency, asthma, malignancy, and obesity.

Similarly, a greater proportion of Maaori children have pre-existing health conditions of a kind that makes them susceptible to more severe COVID-19 outcomes than the general Aotearoa New Zealand child population. These pre-existing health conditions include (but are not necessarily limited to) chronic respiratory conditions, cardiovascular conditions, diabetes, asthma, and obesity.

2.2.2.2 Housing statistics

It is common amongst Maaori, in accordance with custom, for young children to live with older generations of their whaanau. Compared with the general population, it is less common for Maaori to live in the European custom of a “nuclear family”.

Using the Canadian National Occupancy Standard, the 2018 Census of Populations and Dwellings showed that:

- ▶ 20.8 per cent of Maaori lived in overcrowded accommodation compared with 10.8 per cent of the total population; and
- ▶ 7.8 per cent of accommodation for Maaori met the definition of ‘severely crowded’, compared with 3.7 per cent for the total population.

Over-crowded housing limits the ability of Maaori to self-isolate when infected by, or potentially exposed to, SARS-COV-2. This significantly increases the likelihood that the infection of one member in an over-crowded household will lead to the other members in the same household also contracting COVID-19. This increases the likelihood of transmission amongst Maaori.

5. The agreed statement of facts reflects what was known and agreed on the date it was submitted. Some of those agreed facts may now be outdated. For example, as at the date of this report, Medsafe has approved the paediatric use of the Pfizer vaccine.

2.2.2.3 Poverty

Māori, including Māori children, are more likely to live in poverty. According to Statistics New Zealand, in the year ended June 2020, 17.1 per cent of Māori children lived in households with less than 50 per cent of the median equivalised disposable household income before housing costs are deducted, compared with 13.8 per cent for Aotearoa New Zealand overall.⁶

2.2.2.4 Rural populations and COVID-19

According to the New Zealand 2018 Census of Populations and Dwellings, a higher proportion of the Māori population live in small urban areas (14.6 per cent of the Māori population) and rural areas (18.3 per cent), compared with the total population (10.3 per cent and 16.0 per cent respectively). Small urban and rural areas have less medical infrastructure to respond to a COVID-19 outbreak in their community. Populations in small urban and rural areas also face unique home isolation needs in relation to accessing food and services.

2.2.2.5 Children

Data from the 2018 Census suggests that approximately 15.8 per cent of the total Aotearoa New Zealand population are under 12 years old.

Data from the 2018 Census suggests that approximately 25.9 per cent of the Māori population are under 12 years.

Māori preschool children attended some form of formal early childhood education at about the same rate as the general population. Māori primary school aged children are enrolled in primary school at the same rate as the general population. Because a far greater proportion of the Māori population are of such an age (25.9 per cent compared with 15.8 per cent), this means that a far greater proportion of the Māori population are attending formal early childhood education or primary school.

2.2.3 Vaccine and vaccinations

2.2.3.1 Vaccine

The Pfizer vaccine, which is available in Aotearoa New Zealand, has been proven to be safe and effective. Two doses of the vaccine are very effective at reducing the likelihood of severe illness requiring hospitalisation.

By reducing the likelihood of infection amongst those who are vaccinated, the Pfizer vaccine can also reduce the overall level of community transmission.

6. Statistics New Zealand, describing household equivalised disposable income, stated 'to account for differences in household sizes and compositions, income estimates are equivalised to standardise income measures, while considering the economies of scale that arise from the sharing of dwellings. Larger households usually require a greater level of income to maintain the same material standard of living as smaller households, and the needs of adults are usually greater than the needs of children?' See 'Household Income and Housing Cost Statistics Year Ended June 2019', Statistics New Zealand, <https://www.stats.govt.nz/information-releases/household-income-and-housing-cost-statistics-year-ended-june-2019>, accessed 15 December 2021.

2.2.3.2

Receiving one dose of the Pfizer vaccine provides measurably significant benefits. However, far greater benefits come from receiving two doses of the Pfizer vaccine at least three weeks apart. Even after the second dose, the level of protective immunity may differ among people depending on individual factors that may affect the immune response (for example, age, pre-existing health conditions). Based on international evidence of waning immunity, a booster dose at least six months after the second dose has been introduced. A third dose has also been introduced for those who are immunocompromised.⁷

The Pfizer vaccine has so far been provisionally approved by Medsafe for use only by people aged 12 and above.

2.2.3.2 Vaccination rollout process

The Government's vaccination sequencing framework was made up of four main groups. A high-level description of the groups:

- ▶ border and M1Q workforce, and their household contacts;
- ▶ frontline workers and people living in high-risk settings, including people in long-term residential care and people living in Counties Manukau who have certain health conditions or are 65 years or older;
- ▶ people at higher risk, such as older people, people with certain health conditions or disabilities; and
- ▶ the remainder of the general population.

2.2.3.3 Paediatric vaccine

Pfizer has submitted data to Medsafe for the approval of their COVID-19 vaccine in children aged 5–11 years. The Food and Drug Administration in the United States has examined that data and has granted an emergency use authorisation for this age group in that country.

Medsafe is presently examining that data and considering whether to provisionally approve the Pfizer vaccine for use with 5 to 11-year-olds in New Zealand.

2.2.3.4 Vaccination rates

As of 23 November 2021, the Ministry of Health estimates that it has delivered first doses of the Pfizer vaccine to 77.0 per cent of the total New Zealand population and second doses of the Pfizer vaccine to 70.4 per cent of the total New Zealand population.

As of 23 November 2021, the Ministry of Health data shows that it has delivered first doses of the Pfizer vaccine to 58.9 per cent of the total Māori population and second doses of the Pfizer vaccine to 47.9 per cent of the total Māori population.

7. The National Cancer Institute defines immunocompromised as: 'having a weakened immune system. People who are immunocompromised have a reduced ability to fight infections and other diseases'. See 'Immunocompromised'; National Cancer Institute, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/immunocompromised>, accessed 15 December 2021.

2.2.4 Whaanau hauaa / taangata whaikaha

According to the Ministry of Health and results from the 2013 New Zealand Disability Survey, Maaori experience a higher rate of disability than non-Maaori, regardless of age. Disabilities create additional barriers to accessing health information and services, including the Pfizer vaccine. Data collection on the rates of Whaanau hauaa (Maaori disabled) who are vaccinated is not complete.

In 2013, 26 per cent of the Maaori population (176,000 people) identified as disabled.

According to the Ministry of Health and results from the 2013 New Zealand Disability Survey, Maaori experience a higher rate of disability than non-Maaori, regardless of age.

Disabled people are more likely to experience barriers in accessing primary healthcare than those without disabilities, and experienced additional barriers during COVID-19.

In 2013, disease or illness was the most common cause of impairment among disabled Maaori, with 40 per cent having impairments caused by disease or illness.

Underlying disease and illness make whaanau hauaa more susceptible to worse COVID-19 outcomes.

While noting some exceptions, in relation to health and disability services, whaanau hauaa have higher proportions of unmet needs, despite having a higher prevalence of disability.

There is a disproportionately low number of Maaori owned and governed Disability Support Service providers compared to the whaanau hauaa population.

Whaanau hauaa are more likely than Maaori and non-Maaori disabled to have low incomes, experience poverty, poor housing, and unemployment.

2.2.5 Delta variant outbreak and Maaori

2.2.5.1 SARS-COV-2 variants

There are different variants of the SARS-COV-2 virus. Some are designated by the World Health Organization to be variants of interest or variants of concern and are given Greek letter designations.

A variant of SARS-COV-2 is considered to be a variant of concern where it has changed to a degree of global public health significance with respect to aspects including the transmissibility and virulence of the virus.

Delta is a variant of concern and is currently the most prevalent variant globally. All current New Zealand community cases of COVID-19 have been caused by the Delta variant.

The Delta variant is highly infectious, with reported instances of transmission occurring during very brief encounters.

Omicron has been recently identified as a variant of concern. COVID-19 cases caused by Omicron have been identified in 40 countries.

Early indications suggest that Omicron may be an even more infectious variant than Delta.

2.2.5.2 *The Delta outbreak and Maaori*

As of 23 November 2021, during the Delta-variant outbreak which began in August 2021, Maaori have represented 43 per cent of COVID-19 cases, 32 per cent of all hospitalised cases, and 43 per cent of all deaths.

2.2.6 Modelling and Maaori

The modelling detailed in the evidence of Professor Shaun Hendy and George Whitworth was relied upon by the Crown in making its COVID-19 response decisions and that was the only modelling relied upon.

2.3 THE LEGISLATIVE AND POLICY FRAMEWORK SUPPORTING THE COVID-19 PANDEMIC RESPONSE

2.3.1 Key legislation

The Crown has employed several instruments to introduce restrictions and enforce Aotearoa New Zealand's approach to COVID-19. This section focuses on the legislative context underpinning the COVID-19 Protection Framework, generally known as the 'traffic light system'. Our discussion focuses on the COVID-19 Public Health Response Act 2020, the relevant amendments, and how these have been utilised to implement the Crown's approach to the pandemic.

The instruments the Crown has used in responding to different aspects of the COVID-19 pandemic include orders and notices. These are empowered by and give effect to different legislative provisions, such as those contained in the COVID-19 Public Health Response Act 2020.

A number of orders initially issued under the Public Health Act 1956 have since been replaced by orders under the COVID-19 Public Health Response Act 2020.⁸ For example, the COVID-19 Public Health Response (Alert Level Requirements) Order (No 12) 2021 updated the requirements and restrictions of the Alert Level Framework, the details of which are summarised later in this chapter.

The Crown has also issued notices which dictate border requirements in accordance with prior orders, and further notices relating to the Epidemic Preparedness Act 2006 and the Civil Defence Emergency Management Act 2002. Under section 70 of the Public Health Act 1956, notices can also be issued by an authorised medical officer of health to require specified persons to meet public health requirements, such as undergoing testing and isolation until results are received.⁹ Any direction received under this section must be complied with.¹⁰

8. 'Legislation and Key Documents', Unite against COVID-19, <https://covid19.govt.nz/about-our-covid-19-response/legislation-and-key-documents/#key-legislation>, last modified 29 November 2021.

9. For example, on 15 October 2021 the Director-General of Health issued directions outlining isolation and medical testing requirements for people who returned a positive test for COVID-19.

10. 'Legislation and Key Documents', Unite against COVID-19, <https://covid19.govt.nz/about-our-covid-19-response/legislation-and-key-documents/#key-legislation>, last modified 29 November 2021.

2.3.1.1 *The COVID-19 Public Health Response Act 2020 and amendments*

The COVID-19 Public Health Response Act 2020 introduces a tailored legal framework for responding to COVID-19 and came into force on 13 May 2020.¹¹ The purpose of the Act is to support a public health response to COVID-19 that:

- ▶ prevents and limits the risk of the outbreak or spread of COVID-19;
- ▶ avoids, mitigates or remedies the potential adverse effects of the outbreak;
- ▶ is coordinated, orderly, and proportionate;
- ▶ allows social, economic, and other factors to be taken into account where it is relevant to do so;
- ▶ is economically sustainable and allows for the recovery of managed isolation or quarantine facility costs; and
- ▶ has enforceable measures, in addition to relevant voluntary measures and public health and other guidance that also supports the response.¹²

The most significant section of the Act is section 11, which empowers the Minister of Health (or the Director-General of Health in specific circumstances) to make orders to give effect to the public health response to COVID-19 in Aotearoa New Zealand and limit the risk of outbreak or spread of the disease. A COVID-19 order may impose requirements, restrictions, directions, or conditions for different circumstances on different classes of people, places, premises, and other things.¹³ This could include orders requiring people to stay in a specified place, limit their association with others, restrict personal travel, isolate or quarantine, and report for medical examination or testing.¹⁴ Section 20 of the Act grants powers to enforce any aspect of a COVID-19 order.

An order issued under the Act can only be made if a prerequisite contained in section 8 of the Act has been satisfied. These prerequisites are that:

- ▶ an epidemic notice under section 5 of the Epidemic Preparedness Act 2006 is in force;
- ▶ a state of emergency or transition period in respect of COVID-19 under the Civil Defence Emergency Management Act 2002 is in force; or
- ▶ the Prime Minister, by notice in the *Gazette*, after being satisfied that there is a risk of an outbreak or the spread of COVID-19, authorises the use of COVID-19 orders.

2.3.1.2 *The COVID-19 Response (Vaccinations) Legislation Act 2021*

The COVID-19 Response (Vaccinations) Legislation Act 2021 came into force on 26 November 2021. It introduces amendments to the COVID-19 Public Health Response Act 2020 that are aimed at assisting the Government to better manage and recover from the impacts of COVID-19. The Act largely incorporates

11. COVID-19 Public Health Response Act 2020; 'Covid-19: Epidemic Notice and Orders', Ministry of Health, <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-response-planning/covid-19-epidemic-notice-and-orders#phresponseact>, last modified 29 November 2021.

12. COVID-19 Public Health Response Act 2020, s 4.

13. *Ibid*, s 12.

14. *Ibid*, s 11.

further provisions in relation to vaccinations, including broadening the scope of the orders which can be made under section 11 of the COVID-19 Public Health Response Act 2020. Under these provisions, orders can now be made that require a person to produce a vaccination certificate to enter certain premises, specify the required doses for each COVID-19 vaccine, and set further requirements in relation to vaccination certificates such as how they are issued and who is eligible.¹⁵

2.3.2 The roles of the Ministers involved

The current Minister for COVID-19 Response is the Honourable Chris Hipkins. He is supported by the COVID-19 All-of-Government Response Group (COVID-19 Group), a business unit of the Department of the Prime Minister and Cabinet. Leadership and coordination across government is provided by the COVID-19 Group, which is responsible for integrating strategy and policy, system readiness and planning, insights and reporting, system risk and assurance, and public engagement and communications. The COVID-19 Group also delivers a national communications and public engagement campaign.¹⁶

Other Ministers have legislative responsibilities, decision-making rights, and powers in relation to COVID-19 under the legislative framework. They include the Minister of Health (the Honourable Andrew Little), who is responsible for a range of public health decisions including the making of orders under the COVID-19 Public Health Response Act 2020.¹⁷ The Associate Ministers of Health are the Honourable Peeni Henare, the Honourable Dr Ayesha Verrall, and the Honourable Aupito William Sio.¹⁸

The Minister of Immigration, the Honourable Kris Faafoi, is responsible for determining which categories of non-citizens can travel to Aotearoa New Zealand.¹⁹ Additionally, a unit within the Ministry of Business Innovation and Employment is responsible for operating managed isolation and quarantine facilities.²⁰ The Director-General of Health, Dr Ashley Bloomfield, is also able to make orders and issue directions to manage the pandemic.²¹

15. COVID-19 Response (Vaccinations) Legislation Act 2021.

16. Department of the Prime Minister and Cabinet, 'Ministerial Portfolio: COVID-19 Response', <https://dpmc.govt.nz/cabinet/portfolios/covid-19-response>, last modified 6 November 2020; Department of the Prime Minister and Cabinet, *Briefing to Incoming Ministers: COVID-19 Overview*, (Wellington: Department of the Prime Minister and Cabinet, 2020), https://www.beehive.govt.nz/sites/default/files/2020-12/COVID-19_Overview.pdf, p 5.

17. Department of the Prime Minister and Cabinet, *Briefing to Incoming Ministers: COVID-19 Overview*, p 9.

18. 'Health', New Zealand Government, <https://www.beehive.govt.nz/portfolio/labour-2020-2023/health>, accessed 2 December 2021.

19. Department of the Prime Minister and Cabinet, *Briefing to Incoming Ministers: COVID-19 Overview*, p 9, p 9.

20. 'About MIQ', Managed Isolation and Quarantine, <https://www.miq.govt.nz/about/about-miq>, last modified 22 November 2021.

21. COVID-19 Technical Advisory Group, Ministry of Health, <https://www.health.govt.nz/about-ministry/leadership-ministry/expert-groups/covid-19-technical-advisory-group>, last modified 2 June 2021; Department of the Prime Minister and Cabinet, *Briefing to Incoming Ministers: COVID-19 Overview*, p 9, p 9.

2.3.3 The role of Cabinet

Cabinet is the central decision-making body of the executive government where Ministers gather to decide on significant government issues.²² Cabinet considers key COVID-19 policy issues before Ministers exercise their decision-making powers.²³ Ministers take items to Cabinet that concern overall COVID-19 strategy matters such as border settings, key public health measures, and measures to address the economic and social impacts of the pandemic.²⁴ When considering such issues, Cabinet receives advice from the Director-General of Health, which is usually written into the Cabinet papers provided to support Cabinet discussions.²⁵

2.3.4 Other relevant Crown agencies, groups, and committees supporting the response

An interagency COVID-19 Strategy Taskforce was established to oversee implementation of the vaccine strategy. It comprises:

- ▶ the Ministry of Business, Innovation and Employment (as the lead agency);
- ▶ the Ministry of Health and its regulatory agency, Medsafe;
- ▶ Pharmac;
- ▶ the Ministry of Foreign Affairs and Trade; and
- ▶ a Science and Technical Advisory Group (STAG) that supports the taskforce with expert advice about vaccine strategy work.²⁶

The Ministry of Health is the lead agency for the domestic health response and has a COVID-19 Technical Advisory Group.²⁷ Within the Ministry, three planning and delivery groups are responsible for the COVID-19 vaccine plan:

1. The COVID-19 Immunisation Programme Governance Group, which acts as an oversight and assurance body. Its role is to oversee progress on purchasing, sequencing, and delivery of any successful COVID-19 vaccines.
2. The COVID-19 Vaccine and Immunisation Programme Steering Group, which supports the vaccine programme decision-making and provides direction and oversight to the programme team regarding strategic risks, issues, and opportunities.
3. The COVID-19 Immunisation Implementation Advisory Group, which provides independent, practical advice to the Ministry of Health on how to

22. 'Supporting the Work of the Cabinet', Department of the Prime Minister and Cabinet, <https://dpmc.govt.nz/our-business-units/cabinet-office/supporting-work-cabinet>, last modified 6 November 2020.

23. Department of the Prime Minister and Cabinet, *Briefing to Incoming Ministers: COVID-19 Overview*, p9.

24. Ibid.

25. Ibid.

26. 'COVID-19: Who We're Working With', Ministry of Health, <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-strategy-planning-insights/covid-19-who-were-working>, last modified 8 November 2021.

27. 'COVID-19 Technical Advisory Group', Ministry of Health, <https://www.health.govt.nz/about-ministry/leadership-ministry/expert-groups/covid-19-technical-advisory-group>, last modified 2 June 2021; Department of the Prime Minister and Cabinet, *Briefing to Incoming Ministers: COVID-19 Overview*, p11.

plan, prepare, and implement a COVID-19 immunisation campaign, in the event suitable vaccines become available.²⁸

The government agency responsible for facilitating engagement with iwi on the COVID-19 response is Te Arawhiti. It provides advice to the Honourable Kelvin Davis, the Minister for Maaori Crown Relations, and the Honourable Andrew Little, the Minister for Treaty of Waitangi Negotiations. The agency also contributes to policy advice provided by other Crown agencies responsible for the Government's response.²⁹ Te Arawhiti has also established and distributed government funding to support Maaori communities in promoting and delivering the vaccine rollout.³⁰

The National Crisis Management Centre 'facilitates the Central Government crisis management arrangements and offers inter-agency and scalable operability to deal with any type of emergency'.³¹ The centre was activated during the first lockdown in March to April 2020.³²

2.3.5 Key planning documents

2.3.5.1 National action plans

On 17 March 2020, an Initial National Action Plan summarising the emergence and spread of COVID-19 and the actions taken by Cabinet to date was released.³³ This initial plan identified factors which could influence the level of impact the outbreak would have on Aotearoa New Zealand, including the clinical severity and transmissibility of the virus, the capacity of the health system, and the vulnerability of the population.

A more detailed National Action Plan 2 was operational from 25 March 2020 (when the Government declared a State of National Emergency) for an initial period of four weeks.³⁴ The purpose of this plan was to direct the national response during the COVID-19 Alert Level 4 period and to ensure operational alignment with the strategic intent.³⁵ The plan outlined designated objectives by function, and steps that would be taken to achieve priorities.³⁶

National Action Plan 3 was issued on 22 April 2020 and was operational until the next iteration of the all-of-government instruction. Its purpose was to

28. 'COVID-19: Who We're Working With', Ministry of Health, <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-strategy-planning-insights/covid-19-who-were-working>, last modified 8 November 2021.

29. Document D46, p 2.

30. Ibid.

31. 'National Crisis Management Centre', National Emergency Management Agency, <https://www.civildefence.govt.nz/about/national-crisis-management-centre>, accessed 2 December 2021.

32. National Crisis Management Centre, *National Action Plan 2.0* (Wellington: Ministry of Health, 2020), <https://covid19.govt.nz/assets/resources/legislation-and-key-documents/covid-19-national-action-plan-2-issued-1-April.pdf>, p 1.

33. Ibid, pp 23–24.

34. Ibid, p 1.

35. Ibid, p 5.

36. Ibid, pp 9–21.

direct the all-of-government and nationwide effort during the next phase of the response, to ensure operational alignment with the strategic intent, and to provide a single reference for the National Crisis Management Centre objectives and high-level actions during the transition to an all-of-government response model.³⁷ It was to be read alongside other operational plans, including the COVID-19 Maaori Response Action Plan and the Ministry of Health's Health & Disability Response Plan, but did not supersede these.

Under National Action Plan 3, Aotearoa New Zealand's strategy continued to be to eliminate COVID-19 and stamp out transmission within affected clusters, in line with the New Zealand Influenza Pandemic Plan and the four-level COVID-19 Alert Level Framework. It was described as a short-term plan, though it referred to some actions that would be ongoing or extend through to the medium term.³⁸ The plan noted an all-of-government commitment to working in partnership with Maaori as a key component of the COVID-19 national response, the plan recognised Maaori as a priority group within this response.³⁹

No plan has yet superseded National Action Plan 3.

2.3.5.2 Maaori Response Action Plans

The *Initial COVID-19 Maaori Response Action Plan* was published on 16 April 2020. It established a framework to ensure the health and well-being of Maaori was protected during the COVID-19 pandemic. The plan also proposed a strategic approach (and other actions) that would ensure the Crown's COVID-19 response upheld Te Tiriti o Waitangi and supported the achievement of Maaori health equity.⁴⁰ The plan acknowledged that indigenous health inequities exist in Aotearoa New Zealand, and also that unequal distribution of and exposure to the determinants of health increases risk for Maaori.⁴¹ The *Initial COVID-19 Maaori Response Action Plan* was aligned with the framework and content of the COVID-19 Health and Disability System Response Plan to ensure the COVID-19 response for Maaori was integrated with the broader health and disability system response.

An updated *COVID-19 Maaori Response Action Plan* was published on 9 July 2020. It built on progress made in the initial plan and feedback received, setting out an updated framework to protect, prevent, and mitigate the impacts of COVID-19 within whaanau, hapuu, iwi, and Maaori communities. It also supported the Crown in meeting its obligations under Te Tiriti o Waitangi in the COVID-19

37. National Crisis Management Centre, *National Action Plan 3* (Wellington: Ministry of Health, 2020), <https://covid19.govt.nz/assets/resources/legislation-and-key-documents/COVID19-National-Action-Plan-3-as-of-22-April-extended.pdf>, p 3.

38. *Ibid*, p 3.

39. *Ibid*, p 4.

40. Ministry of Health, *Initial COVID-19 Maaori Response Action Plan* (Wellington: Ministry of Health, 2020), https://www.health.govt.nz/system/files/documents/publications/initial_covid-19_maaori_response_action_plan_-_web_.pdf, pp 4–5.

41. Document D47, p 4.

response.⁴² The *Updated COVID-19 Maaori Health Response Plan* was to be supported by *Whakamaaua: The Maaori Health Action Plan, 2020–2025*.⁴³

The *Updated COVID-19 Maaori Health Response Plan* recognised the need for equity to be a central feature of the health and disability system's COVID-19 response and implemented in decision-making.⁴⁴ It identified three objectives that were guided by Te Tiriti o Waitangi principles:

- ▶ ensuring iwi, hapuu, whaanau, and Maaori communities can exercise their authority to respond directly to the health and well-being challenges across the COVID-19 response;
- ▶ ensuring the health and disability system delivers equitable outcomes for Maaori in the COVID-19 response; and
- ▶ ensuring Tiriti and Maaori health equity responsibilities are met in the exercise of kaitiakitanga and stewardship over the COVID-19 response.⁴⁵

Meeting these three objectives would require the health and disability system and government taking action in several areas, including the provision of funding to support Maaori providers and communities, kaupapa Maaori and whaanau-centred models of care, monitoring and accountability, and longer-term strategic planning for recovery and redesign.⁴⁶ The updated plan also provided progress updates on actions set out in the *Initial COVID-19 Maaori Response Action Plan*, which fell into three main categories: actions as part of the Maaori Health Funding Package, contributory actions across the health and disability system, and contributory actions across government. The updated plan tracked these against the response, recovery, and redesign phases of the Ministry's approach to COVID-19.⁴⁷ The updated plan also formalised the governance arrangements for the COVID-19 Maaori health response by providing a framework.⁴⁸

The *Updated COVID-19 Maaori Health Response Plan* set up an initial monitoring framework with three main components: surveillance, system performance, and actions. It establishes a Maaori Monitoring Group to provide insights and advice to inform the Ministry's response and act as an accountability and monitoring mechanism.⁴⁹ The updated plan also outlines an approach to strategic, media, national, and regional communications, strengthened by five Maaori communication principles: kanohi ki te kanohi, kanohi kitea, he ngaakau Maaori, he ngaakau huumaarie, and te mita o te reo.⁵⁰

42. Ministry of Health, *Updated COVID-19 Maaori Health Response Plan* (Wellington: Ministry of Health, 2020), <https://www.health.govt.nz/system/files/documents/publications/updated-covid-19-maori-health-response-plan-jul20.pdf>, p 9.

43. Ibid, p 5.

44. Ibid, pp 6, 38.

45. Ibid, p 9.

46. Ibid, p 10.

47. Ibid, p 20.

48. Ibid, p 32.

49. Ibid, p 33.

50. Ibid, pp 34–35.

2.3.5.3 *Response and resurgence plans*

The Government has also released two response and resurgence plans since the COVID-19 pandemic began:

- ▶ ‘Stamp it Out: Our plan to respond to new COVID-19 cases in the community’ (July 2020); and
- ▶ ‘Rapid response to cases of COVID-19 in the community’ (August 2020).⁵¹

‘Stamp it Out’ noted that, even with border facilities and testing regimes, the risk of new community cases was high and needed to be prepared for. The plan outlined a four-pillar approach to reducing the chance of a new outbreak: border controls, surveillance and testing, contact tracing, and hygiene measures. Any response to new cases of COVID-19 beyond the border was to be underpinned by three key objectives and five key principles. The objectives were to minimise the number of people infected and potentially exposed to COVID-19, minimise the negative health outcomes for those infected with COVID-19, and minimise the economic and social impacts of any control measures. The key principles were:

- ▶ to continue to pursue an elimination strategy for COVID-19;
- ▶ maintain personal hygiene, staying home when sick, testing, contact tracing, and isolation at the core of the response;
- ▶ where this approach is insufficient, seek to control COVID-19 with the least intrusive measures (including tailored local responses) that give confidence the Government will continue to deliver on the strategy of elimination;
- ▶ seek to avoid going to Alert Levels 3 or 4 (except where necessary); and
- ▶ ensure strong national oversight over any response.

‘Stamp it Out’ also developed three possible scenarios involving new cases, from a contained cluster within a community to multiple clusters with national spread, and likely responses that would be taken by the Government in each case.⁵²

In August 2020, the Government released a further rapid response and resurgence plan to respond to COVID-19 cases in the community. The key principles for the rapid response plan were to continue to pursue an elimination strategy, maintain personal hygiene, staying home when sick, testing, contact tracing and isolation at the core of the response, and a rapid response to prevent further transmission while information is gathered to inform decisions.

The rapid response set out in this plan had two stages. Stage one was for when a case was confirmed in the community. The region where the case was identified would have a range of controls (such as restricting movement) similar to those at Alert Level 3 and applying for a limited time while information was gathered, and contact tracing and testing begun. Based on information gathered in stage one and public health advice, a group of Ministers would then make a decision about stage

51. ‘Legislation and Key Documents’, New Zealand Government, <https://covid19.govt.nz/about-our-covid-19-response/legislation-and-key-documents>, last modified 29 November 2021.

52. ‘Stamp it Out: Our Plan to Respond to New COVID-19 Cases in the Community’, New Zealand Government, <https://covid19.govt.nz/assets/resources/legislation-and-key-documents/Stamp-it-Out-one-pager.pdf>.

two. The plan outlined different scenarios which would impact decisions about alert levels locally and nationally and provides response examples.⁵³

2.4 THE COVID-19 ALERT LEVEL FRAMEWORK

2.4.1 Overview

At the beginning of the COVID-19 outbreak in Aotearoa New Zealand, the Government adopted a zero tolerance response, termed the 'elimination strategy'.⁵⁴ This involved strict controls at the border to prevent COVID-19 from entering from overseas, and other controls across the country aimed at eliminating COVID-19 when it entered the community.⁵⁵ The COVID-19 Alert Level Framework, which came into effect on 21 March 2020, was the first control measure by which the Government managed the pandemic in accordance with this strategy.⁵⁶

In the framework, the Alert Levels specified the procedures that had to be adhered to in order to eliminate COVID-19.⁵⁷ The Alert Level Framework was updated, according to new scientific knowledge about COVID-19, information about the effectiveness of control measures in Aotearoa New Zealand, and/or the application of Alert Levels at different times (for example, the application may have differed depending on if the country moved down or up Alert Levels).⁵⁸ Different parts of the country could also be at different Alert Levels, and could move up and down these levels. Restrictions at the different Alert Levels were cumulative (for example, at Alert Level 4, all restrictions at Alert Levels 1, 2 and 3 applied). However, services such as supermarkets, health services, emergency services, utilities, and goods transport continued to operate at any level, and employers in these sectors were required to continue to meet health and safety obligations.

53. New Zealand Government, *Rapid Response to Cases of COVID-19 in the Community* (Wellington: New Zealand Government, 2020), <https://covid19.govt.nz/assets/resources/legislation-and-key-documents/Rapid-response-one-pager.pdf>.

54. Document D51, p 2.

55. Ibid.

56. Prior to the Alert Level System, on 14 March 2020 the Government required anyone entering New Zealand to isolate for 14 days, except those arriving from the Pacific. On 19 March 2020, all indoor gatherings of more than 100 people were cancelled and the borders were closed to all, except for New Zealand citizens and permanent residents: 'History of the COVID-19 Alert System', New Zealand Government, <https://covid19.govt.nz/about-our-covid-19-response/history-of-the-covid-19-alert-system/#timeline-of-key-events>, last modified 29 November 2021.

57. The information contained in this section is taken from New Zealand Government, *New Zealand COVID-19 Alert Levels Summary* (Wellington: New Zealand Government, 2021), <https://covid19.govt.nz/assets/resources/tables/COVID-19-Alert-Levels-summary-table.pdf>, and New Zealand Government, *New Zealand COVID-19 Alert Levels* (Wellington: New Zealand Government, 2021), <https://covid19.govt.nz/assets/resources/tables/COVID-19-Alert-Levels-detailed-table.pdf>.

58. 'About the Alert System', New Zealand Government, <https://covid19.govt.nz/about-our-covid-19-response/about-the-alert-system>, last modified 29 November 2021.

2.4.2 The alert levels

2.4.2.1 Alert Level 1: prepare

The Government employed this Alert Level when the disease was contained in Aotearoa New Zealand. At Alert Level 1, COVID-19 was uncontrolled overseas, and there could be occasional imported cases and isolated local transmission in the country. The goal was to keep the pandemic out of the country, but to be prepared for increases in Alert Levels if necessary.

At Alert Level 1, all businesses, facilities, schools, education providers and workplaces could be open. Record-keeping was required, and Aotearoa New Zealand COVID Tracer QR codes had to be displayed in most public facilities. Individuals were encouraged to keep track of their own movements to assist with contact tracing and help identify any potential spread of COVID-19. Face coverings were to be worn while using public transport, with exclusions based on age, disability and mental health.

2.4.2.2 Alert Level 2: reduce

A move to Alert Level 2 indicated a low risk of community transmission within a specified area. At this level, there could be limited community transmission and active clusters in more than one region. Physical distancing was imposed in workplaces, and gatherings were restricted to address any sporadic cases or clusters.

At Alert Level 2, people could still connect with each other in person, socialise in groups, and go shopping and travel domestically, according to public health guidance. While people could attend their place of work or learning, alternative ways of working were encouraged. Businesses, schools, early learning services, tertiary education providers, and public facilities (such as museums, libraries, and pools) could open with additional health measures in place. Gatherings of up to 100 people were allowed in a defined space, including weddings, funerals, and tangihanga.

Record-keeping was mandatory, and physical distancing measures required people to be two metres apart from strangers in public places (such as retail stores), and one metre apart in other places, such as office buildings and places where there was a cap on numbers. Hospitality businesses were required to keep groups of customers separated and seated. Event facilities such as cinemas and concert venues could open. All these venues were required to follow physical distancing requirements which determined the maximum capacity of the businesses.

Under Alert Level 2, face coverings were mandatory in more places. People aged 12 and over were required to wear face coverings on public transport, retail businesses, and public facilities. Some workers whose occupations put them in close contact with others (for example, drivers of taxis or ride-share vehicles, retail staff, and workers at indoor public facilities) were also required to wear face coverings.

Health and disability care services were able to operate as normally as possible. People at a higher risk of severe illness from COVID-19, such as those with underlying medical conditions and older people, were encouraged to take additional

2.4.2.3

precautions when leaving home, unless fully vaccinated. These people could attend work if their employer agreed they could do so safely.

Sports and recreational activities were allowed, subject to conditions on gatherings, record-keeping, and physical distancing where practical.

2.4.2.3 Alert Level 3: restrict

A shift to Alert Level 3 indicated multiple cases of community transmission, with active but managed clusters in multiple regions. At this level, activities were further restricted, and people were required to stay at home other than for essential personal movement.

At Alert Level 3, people were required to remain in their immediate household 'bubble', but it could be extended to include close family, to enable caregiving, or to support isolated people. Travel was restricted to essential personal movement, such as accessing local businesses, health and other services.

The same Level 1 and 2 requirements for wearing face coverings applied at Level 3, but people were also required to wear them if indoors at secondary school and if they worked as a delivery driver visiting residential addresses.

Gatherings of up to 10 people were allowed for weddings and civil union ceremonies, funerals, and tangihanga (excluding staff members). Physical distancing conditions required people to keep a two-metre distance from others while in public, or one metre in controlled environments like workplaces. Customers were only allowed inside essential businesses, such as supermarkets. Other businesses could open if they could operate in a contactless way.

Public facilities were closed, but early childhood centres and schools could open for students up to Year 10, for those who were unable to learn from home.

Health care services were encouraged to use virtual, non-contact consultations where possible.

2.4.2.4 Alert Level 4: lockdown

At Alert Level 4, it was likely the disease was not contained, there were widespread outbreaks, and community transmission was sustained and intensive. All movement and contact were strongly restricted.

At this Alert Level, people were required to stay at home in their immediate household bubble and no domestic travel was allowed. Essential personal movement was restricted even further than at Alert Level 3 and was permitted only for essential travel to purchase or access necessities and safe recreational activities.

Everyone was required to work and learn from home, with some exceptions for essential workers and their children. No gatherings were allowed, and all public and educational facilities closed. Members of a household or shared bubble could accompany a deceased person in a funeral home, cemetery, or faith-based institution subject to strict conditions.

All businesses were required to close except for essential services such as supermarkets, pharmacies, petrol stations, and lifeline utilities. Rules regarding face coverings were the same as under Alert Level 3 and it was recommended people wear face coverings whenever leaving the house.

The rationing of supplies and requisitioning of facilities, as well as the reprioritisation of healthcare services, were also possible.

2.4.3 Amendments to the alert levels

On 17 August 2021, all of Aotearoa New Zealand moved to Alert Level 4 after a community case of the Delta variant was detected in Auckland.⁵⁹ On 31 August 2021, all of the country apart from Auckland moved to Alert Level 3; Auckland remained at Alert Level 4 until 21 September 2021, when it moved to Alert Level 3.⁶⁰ Meanwhile, the rest of the country had moved to Alert Level 2 on 7 September.⁶¹ Areas in the Waikato region also moved to Alert Level 3 on 3 October 2021.

On 4 October 2021, the Government announced a variation to the Alert Level Framework for the Auckland area.⁶² This announcement outlined a broad roadmap for easing restrictions for Auckland while at Alert Level 3.⁶³ The phased approach would occur in three steps, and at each stage the Government would assess the impact of the previous step before stepping down further.⁶⁴ It was confirmed Auckland would move to Step 1 in this announcement, and movement to further steps was to be assessed weekly on an ongoing basis.

Auckland transitioned into Step 1 on Tuesday 5 October, 11:59pm, followed by the areas in Waikato still in Alert Level 3 on 27 October 2021.⁶⁵ At Step 1, people were able to connect with loved ones outdoors, in groups of no more than 10 people from two different households. Face masks were required but could be removed to eat and drink.⁶⁶ Children could return to early childhood education centres, providing the facilities could maintain bubbles of no more than 10 children on sites. Parents were required to wear masks during pick-up and drop-off and teachers were encouraged to get tested for COVID-19 when returning to work.⁶⁷ People could move around Auckland for outdoor recreational activities, keeping to the maximum of 10 people. Funerals, tangihanga, weddings, and civil unions were capped at 10 people (including staff).⁶⁸

On 1 November 2021, the Government announced that Waikato would move into Step 2 the next day, followed by Auckland on 9 November.⁶⁹ At Step 2, retail businesses and public facilities were able to open with face covering and physical

59. Submission 3.2.413(a), p 3.

60. Ibid.

61. Ibid.

62. Right Honourable Jacinda Ardern, 'Auckland Roadmap – Restrictions Eased in Steps', media release, 4 October 2021, <https://www.beehive.govt.nz/speech/auckland-roadmap-%E2%80%93-restrictions-eased-steps>.

63. Ibid.

64. Ibid.

65. Submission 3.2.413(a), p 4; Ardern, 'Auckland Roadmap – Restrictions Eased in Steps'.

66. Ardern, 'Auckland Roadmap – Restrictions Eased in Steps'.

67. Ibid.

68. Ibid.

69. Submission 3.2.413(a), pp 4–5; Right Honourable Jacinda Ardern, 'Covid-19 Restrictions to Ease in Waikato Tomorrow; Auckland to Move Next Week', media release, 1 November 2021, <https://www.beehive.govt.nz/release/covid-19-restrictions-ease-waikato-tomorrow-auckland-move-next-week>.

distancing requirements.⁷⁰ Outdoor gatherings increased to 25 people and were no longer restricted to two households only.⁷¹ Funerals, tangihanga, weddings, and civil unions could also increase to 25 people, plus up to five staff.⁷²

On 16 November 2021, Waikato shifted into Alert Level 2, and Auckland remained at Step 2 of Alert Level 3.⁷³ The country transitioned into the new COVID-19 Protection Framework prior to Auckland moving to Step 3, which would have lifted restrictions further.⁷⁴ At Step 3, hospitality businesses, such as cafes and bars could reopen with a limit of 50 people. Event facilities such as cinemas and theatres could also open with a limit of 50 people, wearing face coverings and two-metre physical distancing. Close contact businesses, such as hairdressers and barbers, could also reopen if workers wore face coverings. Social gatherings, both indoors and outdoors, could take place with a limit of 50 people in a defined space.

2.5 THE COVID-19 VACCINE AND IMMUNISATION PROGRAMME

2.5.1 Key strategies and plans

2.5.1.1 COVID-19 Vaccine Strategy

In June 2020, the Government agreed to a COVID-19 Vaccine Strategy that sought to ensure all eligible people access to safe and effective vaccines.⁷⁵ The strategy set out the steps the Crown would take to ensure the necessary infrastructure, regulations, and relationships were in place for COVID-19 vaccines.⁷⁶ The purpose of the COVID-19 Vaccine Strategy was to contribute to Aotearoa New Zealand's social, cultural, and economic well-being by reducing the impacts of COVID-19.⁷⁷ In order to achieve these specific outcomes, the Crown developed the COVID-19 vaccine and immunisation programme.

2.5.1.1.1 The COVID-19 vaccine and immunisation programme

The focus of the vaccine and immunisation programme was to ensure everyone in Aotearoa New Zealand, Polynesia, and across the Pacific had access to a safe and effective COVID-19 vaccine as soon as possible, to maximise the uptake of the vaccine by those who were eligible and able to be vaccinated, and to honour and uphold the principles of Te Tiriti o Waitangi.⁷⁸ The Ministry of Health was responsible for building an operational approach to deliver the vaccine and

70. Ardern, 'Auckland Roadmap – Restrictions Eased in Steps'; Ardern, 'Covid-19 Restrictions to Ease in Waikato Tomorrow'.

71. Ardern, 'Auckland Roadmap – Restrictions Eased in Steps'.

72. Ibid.

73. Submission 3.2.413(a), p5.

74. 'Alert Level 3 – Steps 1 to 3', New Zealand Government, <https://covid19.govt.nz/alert-levels-and-updates/alert-level-3/alert-level-3-steps-1-to-3>, last modified on 22 November 2021.

75. Document D48, p3.

76. 'Covid-19: Supporting the Vaccine Rollout', Ministry of Health, <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-strategy-planning-insights/covid-19-supporting-vaccine-rollout>, last modified 22 September 2021.

77. Document D48, p3.

78. Ibid.

immunisation programme. District health boards supported the delivery of the programme and managed the operational planning and delivery of vaccinations at a regional and local level alongside primary care, hauora, community, and non-government organisation providers.⁷⁹

Beyond vaccinating the people of Aotearoa New Zealand, the Crown stated that the vaccine and immunisation programme aimed to provide a 'legacy', in the form of the collection of iwi affiliation data, the creation of a new vaccinator workforce (including kaiaawhina), investment in hauora Maaori providers and the infrastructure supporting them – including the mobilising of services, increasing the capability and capacity to respond to ongoing vaccinations in general, and supporting the response to future epidemics.⁸⁰

The Crown anticipates further steps in the vaccine and immunisation programme as the Ministry of Health and the district health boards continue to work to push population coverage as high as possible, and shift their focus to regions with pockets of lower uptake.⁸¹ Subject to approvals, the Crown will implement further initiatives such as a booster programme (which began on 29 November 2021), access to the Oxford–AstraZeneca vaccine, COVID-19 vaccine certificates, and vaccine orders for select workforces.⁸²

2.5.1.1.2 COVID-19 Maaori Vaccine and Immunisation Plan

On 26 March 2021, the Ministry of Health published the *COVID-19 Maaori Vaccine and Immunisation Plan*.⁸³ Building on the *Updated COVID-19 Maaori Response Action Plan* implemented in July 2020, it outlined key initiatives to ensure the COVID-19 vaccine and immunisation programme addresses its obligations under Te Tiriti o Waitangi and supports Maaori health and equity.⁸⁴ The *Maaori Vaccine and Immunisation Plan* was intended to help manage the impact of COVID-19 on whaanau, hapuu, iwi, and hapori Maaori by helping to actively protect people from the potential harm of contracting COVID-19, potentially reducing the risk of transmission in the community, and supporting the health and disability system's readiness and resilience in the event of an outbreak. This was to be achieved both by vaccinating certain health workers early and by vaccinating the groups most at risk of severe illness if they contract COVID-19.⁸⁵ The plan stated that the overarching goal of the COVID-19 vaccine and immunisation programme was to ensure as many people received the vaccine as early as possible, whilst upholding the Crown's obligations under Te Tiriti o Waitangi. The Ministry's Te Tiriti obligations

79. Ibid, pp 3, 4.

80. Ibid, p 4.

81. Ibid, pp 37–38.

82. Ibid.

83. Ministry of Health, *COVID-19 Maaori Vaccine and Immunisation Plan: Supplementary to the Updated COVID-19 Maaori Health Response Plan* (Wellington: Ministry of Health, 2021), https://www.health.govt.nz/system/files/documents/publications/covid-19_maori_vaccine_and_immunisation_plan_-_supplementary_to_the_updated_covid-19_maori_health_response_plan.pdf.

84. Ibid, p 3.

85. Ibid.

are derived from our *Hauora* report and are guided by the principles of equity, active protection, options, partnership, and tino rangatiratanga.⁸⁶

Under a series of Treaty principle headings (equity, active protection, options, partnership, and tino rangatiratanga), the *Maaori Vaccine and Immunisation Plan* set out actions that would be consistent with those principles – for example, providing options for a range of urban and rural locations to get a vaccine such as community clinics, marae, and mobile units, and equitable and dedicated funding to Maaori health providers to prepare for the COVID-19 rollout programme.

The *Maaori Vaccine and Immunisation Plan* also outlined the Ministry's investment into five initiatives:

1. governance and partnership: Maaori representation and engagement across all levels of the programme;
2. targeted vaccination approach: for example, 40,000 courses of the vaccine were allocated to Maaori and Pacific providers for early rollout to their vulnerable populations;
3. Maaori health and disability provider support: targeted funding to support Maaori communities and improve vaccination rates;
4. workforce development: culturally specific training for regulated Maaori health workers and development of unregulated community workers to increase the Maaori vaccination workforce; and
5. tailored communications: working with partner organisations such as the Iwi Communications Collective and Te Puni Kookiri to tailor communications to Maaori and further target groups such as rangatahi.⁸⁷

2.5.1.2 Maaori Mobilisation Communications Campaign

Throughout 2021, Te Puni Kookiri led a 'Maaori Mobilisation Communications Campaign' in collaboration with the Ministry of Health, the Department of Prime Minister and Cabinet (DPMC), and the all-of-Government COVID-19 vaccine and immunisation programme.⁸⁸ The objectives of the campaign were to:

- ▶ create a unifying national Maaori plan that motivated Maaori to get vaccinated;
- ▶ ensure information produced was relevant and relatable for Maaori audiences;
- ▶ ensure communications could be customised and accessed by Maaori, iwi, and health providers;
- ▶ complementing the all-of-Aotearoa New Zealand campaign to take a multi-pronged approach to encouraging as many Maaori as possible to get vaccinated; and
- ▶ ensuring the campaign responded to changing needs and research, data, and insights received.⁸⁹

86. Ministry of Health, *COVID-19 Maaori Vaccine and Immunisation Plan: Supplementary*, p 6.

87. *Ibid.*, pp 7–11; doc d48, pp 11–12.

88. Document D45, p 2.

89. *Ibid.*, pp 2–3.

In addition, the ‘Karawhiua’ campaign was developed by Te Puni Kookiri in collaboration with Te Hiringa Hauora and the Iwi Communications Collective, focused on encouraging Māori to actively seek out information about how to best protect their whānau from COVID-19 and to provide information needed to make vaccination decisions.⁹⁰ The Karawhiua campaign was supported by the Ministry of Health, including financially, and to ensure campaigns were complementary.⁹¹

2.5.2 The vaccine rollout

The rollout of Pfizer vaccines across the country was staged, initially due to limited supplies of the vaccine.⁹² The staggered rollout was informed by the COVID-19 Immunisation Sequencing Framework, and the Crown provided early access to the vaccine to those it assessed were most likely to be exposed to, or transmit, COVID-19.⁹³ The Immunisation Sequencing Framework balanced access to vaccines for specific workforces with access for people at risk of severe disease if they did contract the virus.⁹⁴

The Immunisation Sequencing Framework provided for four main groups, with those at highest risk provided access to the vaccines first.⁹⁵ We outline these groups later in this section.

The Crown stated that the Immunisation Sequencing Framework responded to the following constraints:

- ▶ an initially limited and uncertain vaccine supply;
- ▶ emerging evidence on who could be safely vaccinated, which in turn limited the ability to offer vaccines to children at risk, including those who fell into the Group 1 category;
- ▶ strict storage and extreme low temperature refrigeration requirements for the vaccine, which meant that vaccinations were initially restricted to central locations; and
- ▶ the need to minimise wastage, which was another implication of the vaccine’s scarcity and short shelf life. Thawed vaccines were closely matched against bookings, and when vaccines were about to expire, they could be offered to lower priority groups if higher priority people were unavailable at short notice.⁹⁶

The Ministry of Health sought further advice and reviews of the Immunisation Sequencing Framework prior to Cabinet confirmation of the strategy.⁹⁷

90. Ibid, p 3.

91. Document D48, p 22.

92. Approval was later given for the use of two further COVID-19 vaccines, Janssen and AstraZeneca, with AstraZeneca becoming available from 29 November 2021: doc d48, pp 5, 14.

93. Document D48, p 5.

94. Ibid.

95. Ibid.

96. Ibid, pp 5–6.

97. Ibid, pp 6–8.

As at 2 December 2021, vaccination rates were at 93 per cent for the first dose for the eligible population with 86 per cent of the population fully vaccinated.⁹⁸ Māori had reached 83 per cent for the first dose and 69 per cent fully vaccinated (with variable rates across different areas).⁹⁹

Regarding vaccinations for 5–11 year olds, the Crown has indicated that should Medsafe approve the Pfizer vaccine for use in children, an expert advisory group and the Immunisation Implementation Advisory Group will provide further advice on its use in Aotearoa New Zealand.¹⁰⁰ At hearings, Crown witness Joanne Gibbs indicated that approval of a paediatric vaccine is anticipated, and rollout will begin in January 2022, with an emphasis on a whānau-based approach.¹⁰¹

2.5.3 Vaccination groups

The vaccine rollout was targeted at the following groups.¹⁰²

2.5.3.1 Group 1

The first group vaccinated were those most at risk of contracting COVID-19.¹⁰³ Group 1 consisted of people who work at the border or in managed isolation and quarantine facilities, as well as the people they live with.¹⁰⁴ The rollout to Group 1 began in February 2021, with the first vaccinations administered on 19 February 2021.¹⁰⁵

2.5.3.2 Group 2

Group 2 consisted of frontline workers, such as people working in the health system and emergency service workers (police, fire, and ambulance).¹⁰⁶ These workers were identified to be at greater risk of getting COVID-19 or spreading it to people most at risk.¹⁰⁷

As a part of the rollout plan, people living or working in long-term residential care homes (and aged residential care and disability residential support services) were also a part of Group 2. Later, it was decided to expand this group to include high-risk people who lived in South Auckland.¹⁰⁸ Older Māori and Pacific people

98. Document D48, p 37.

99. Ibid.

100. Ibid, p 38.

101. Ibid, pp 38–39.

102. 'Covid-19 Vaccine Rollout Plan', New Zealand Government, <https://covid19.govt.nz/news-and-data/latest-news/covid-19-vaccine-rollout-plan>, last modified 10 March 2021.

103. Ministry of Health, *COVID-19 Vaccine: Communications and Engagement Approach, Version 1* (Wellington: Ministry of Health, 2021), https://www.health.govt.nz/system/files/documents/pages/covid-19_vaccine_communications_and_engagement_approach_v1.pdf, p 4.

104. Document D48, p 5.

105. Ministry of Health, *Communications and Engagement Approach*, p 4; submission 3.2.413(a), p 2.

106. Document D48, p 5; Ministry of Health, *Communications and Engagement Approach*, p 4.

107. Ministry of Health, *Communications and Engagement Approach*, p 4.

108. Document D48, pp 8, 9; Ministry of Health, *Communications and Engagement Approach*, p 4.

cared for by whaanau (and the people they live with, and their carers) were also captured in this group.¹⁰⁹ The rollout for this group began in March 2021.¹¹⁰

2.5.3.3 Group 3

Group 3 included all people aged 65 and over, and people with certain pre-existing health conditions.¹¹¹ People with disabilities were also eligible to access vaccinations as part of Group 3, as they were more likely to experience severe outcomes from COVID-19 infection.¹¹² Group 3 also included adults held in custody.¹¹³ Vaccination of people in this group began in May 2021.¹¹⁴

2.5.3.4 Group 4

COVID-19 vaccinations were opened to the general public on 28 July 2021, beginning with those aged 60–64 years.¹¹⁵ The progression through the age groups occurred over five weeks, faster than originally anticipated.¹¹⁶ Those aged 55 years and over were invited to book a vaccination on 6 August 2021, and those aged 50–54 on 11 August 2021.¹¹⁷ People aged 40–49 were invited to book their vaccination on 18 August 2021 and those aged 30 and over on 25 August 2021.¹¹⁸ Finally, all eligible people aged 12 and over were able to be vaccinated from 1 September 2021.¹¹⁹

2.6 THE COVID-19 PROTECTION FRAMEWORK ('TRAFFIC LIGHT SYSTEM')

2.6.1 Introduction to the Protection Framework

The COVID-19 Protection Framework (the Protection Framework) replaced the Alert Level Framework on 3 December 2021, becoming the new approach to managing COVID-19 in Aotearoa New Zealand.

On 4 October 2021, the Government announced that it would begin a three-step plan to ease restrictions in Auckland, which had been experiencing an outbreak of the Delta variant.¹²⁰ Once Auckland was at Alert Level 2, the country would likely move to a national framework that reflected a more highly vaccinated population.¹²¹

109. Ministry of Health, *Communications and Engagement Approach*, p 4.

110. Ibid.

111. Document D48, p 32.

112. Ibid.

113. Ministry of Health, *Communications and Engagement Approach*, p 4.

114. Ibid.

115. Document D48, p 9.

116. Ibid, p 10.

117. Submission 3.2.413(a), p 3.

118. Ibid.

119. Document D48, p 9.

120. Right Honourable Jacinda Ardern, 'Auckland Restrictions Eased in Steps', media release, 4 October 2021, <https://www.beehive.govt.nz/release/auckland-restrictions-eased-steps>.

121. Ibid.

2.6.2

On 22 October 2021, the Government announced the new COVID-19 Protection Framework, describing it as a ‘simpler framework to minimise cases and hospitalisations without use of widespread lockdowns.’¹²²

2.6.2 Overview of the Protection Framework

The framework is one element of the Government’s shift in focus from eliminating COVID-19, to a ‘minimise and protect’ strategy; the other key elements are vaccinations and border controls.¹²³ The Prime Minister stated in a press release:

The simplified framework has three levels: green, orange and red. Vaccine certificates will provide greater freedoms at each level, and there will be extra public health precautions built in at higher levels to minimise the impact of COVID-19 and suppress the spread of the virus.¹²⁴

The new system allows businesses to open to vaccinated customers when under the green and orange lights, and to continue to operate with some restrictions under red. Businesses choosing to open to unvaccinated people would face restrictions. The Prime Minister initially advised that Auckland would move to the new framework once 90 per cent of the eligible population in the three district health board regions had been fully vaccinated. Prime Minister Ardern stated that the rest of the country would move to the framework once each district health board region reached the same 90 per cent target. Cabinet was set to review vaccination progress on 29 November 2021.¹²⁵

Overall, the transition from the Alert Level Framework to the Protection Framework marked a clear change in the Government’s approach to the pandemic. The introduction of the new system, the Government said, acknowledged that COVID-19 would spread around Aotearoa New Zealand and that, with a vaccinated population, the Protection Framework was the best tool to prepare for this inevitability.

The key components of the Protection Framework are:

- ▶ Minimising the spread of COVID-19 and keeping hospitalisations as low as possible, while containing, and if practical, eliminating any outbreaks (high rates of vaccination among residents of Aotearoa New Zealand will

122. Right Honourable Jacinda Ardern, ‘New Covid-19 Protection Framework Delivers Greater Freedoms for Vaccinated New Zealanders’, media release, 22 October 2021, <https://www.beehive.govt.nz/release/new-covid-19-protection-framework-delivers-greater-freedoms-vaccinated-new-zealanders>.

123. The information contained in this section is taken from the COVID-19 Protection Framework (Traffic Lights): ‘Covid-19 Protection Framework (Traffic Lights)’, New Zealand Government, <https://covid19.govt.nz/alert-levels-and-updates/covid-19-protection-framework>, last modified 4 December 2021; ‘Covid-19 Protection Framework Summary Table’, New Zealand Government, <https://covid19.govt.nz/traffic-lights/covid-19-protection-framework>, last modified 4 December 2021; see also doc d50, p2.

124. Jacinda Ardern, ‘New COVID-19 Protection Framework Delivers Greater Freedoms’.

125. Document D50, p38.

minimise the spread of COVID-19 and are essential to deciding what traffic light will apply to different parts of the country).

- ▶ Responding with a focus on minimising significant health impacts through treatment and support and protecting people's health by ensuring the impact of COVID-19 does not have flow-on effects that impact upon other health services.
- ▶ Using My Vaccine Pass, the official record of a person's COVID-19 vaccination status, to help identify what restrictions apply to individuals and businesses at each traffic light designation.
- ▶ Implementing capacity limits based on a minimum of one-metre distancing.
- ▶ Record-keeping for contact tracing, either manually or by QR codes displayed in workplaces and on public transport to enable the use of the Aotearoa New Zealand COVID Tracer app
- ▶ Using localised lockdowns and protections in addition to the three traffic light settings, if needed.

2.6.3 The traffic lights

The Protection Framework introduced three levels, referred to as 'traffic lights', to manage COVID-19 in the community. Ruth Fairhall, Head of Policy and Strategy in the Department of the Prime Minister and Cabinet, described the Protection Framework's levels as follows:

- ▶ Green aims to allow almost normal social and economic activity, while continuing to build health system capacity.
- ▶ Orange aims to avoid exponential growth in COVID-19 cases with moderate population level controls.
- ▶ Red aims to protect the sustainability of the health system and the health of communities through population-level controls.¹²⁶

The Protection Framework leverages the protections afforded by a highly vaccinated population. It offers New Zealanders greater freedoms when they are fully vaccinated, while employing specific mechanisms to protect vulnerable populations where necessary.¹²⁷

The Protection Framework differentiates between vaccinated and unvaccinated people and applies different restrictions at each light. A shift between lights depends on vaccination coverage, capacity of the health and disability system, testing, contact tracing and case management capacity, and the transmission of COVID-19 in the community, including its impact on key populations.

2.6.3.1 Green light

At green, although COVID-19 is present across Aotearoa New Zealand (including sporadic imported cases), there is limited community transmission, COVID-19 hospitalisations are at a manageable level, and the health system is ready to respond (primary care, public health, and hospitals).

126. Document D50, pp 1–2.

127. Ibid, p 2.

2.6.3.2

There are general settings which apply to everyone at green. Record-keeping is required, face coverings are mandatory for flights, and public facilities, retail, workplaces, and educational facilities are open.

There are no restrictions if My Vaccine Pass is used for visiting hospitality businesses, social gatherings both at home and elsewhere, indoor and outdoor events, close-proximity businesses, and gyms.

In places where My Vaccine Pass is not used, the following restrictions apply:

- ▶ Hospitality spaces and both indoor and outdoor events will be limited to 100 people, based on the ability to apply one-metre distancing, with people seated and separated.
- ▶ Gatherings at homes will be capped at 100 people.
- ▶ Other gatherings (such as weddings, tangihanga, or social sports, or at places of worship or marae), outdoor community events with uncontrolled access, and gyms will be capped at 100 people based on a one-metre distancing requirement.
- ▶ Other close-proximity businesses will require face coverings for staff and one-metre distancing between customers.

2.6.3.2 Orange light

A shift to orange will occur where there is community transmission of COVID-19, with pressure on the health system. The whole of the health system will be focusing its resources but can manage primary care, public health, and hospital care. There might also be an increasing risk for vulnerable people.

As per the general settings, record-keeping or scanning is required. Face coverings are mandatory on flights, public transport, taxis, retail, and public venues, and encouraged elsewhere. Public and retail facilities will be open with capacity limits based on one metre distancing. Workplaces will remain open, and educational institutions will also be open with public health measures in place.

There are no further restrictions if people use My Vaccine Pass when visiting hospitality businesses, social gatherings both at home and elsewhere, indoor and outdoor events, close-proximity businesses, and gyms. If My Vaccine Pass is not used, further restrictions apply:

- ▶ Hospitality areas (for example, cafés, restaurants, and bars) will be contactless only.
- ▶ Gatherings at homes will be limited to up to 50 people.
- ▶ Other gatherings (such as weddings, tangihanga, places of worship, marae and social sports) and outdoor community events (with uncontrolled access) will be limited to up to 50 people, based on one metre social distancing.
- ▶ Close-proximity businesses (for example, hairdressers and beauty salons), indoor and outdoor events, and gyms cannot operate.

2.6.3.3 Red light

At this stage in the framework, action is needed to protect at-risk people and protect the health system from an unsustainable number of hospitalisations.

The general settings for red require continued record-keeping or scanning and mandatory face coverings for flights, public transport, taxis, retail, educational institutions (Year 4 and up, including tertiary institutions), and public venues, and is encouraged elsewhere. Public facilities and retail services may remain open with limited capacity based on one metre social distancing. Educational institutions remain open with public health measures in place. Working from home may be appropriate for some staff.

Unlike in the green and orange levels, some restrictions still apply even with My Vaccine Pass:

- ▶ Hospitality businesses will have a limited capacity of up to 100 people based on one metre distancing, with people seated and separated.
- ▶ Gatherings at home will be limited to 100 people and other gatherings, such as weddings and tangihanga, will be limited to 100 people, based on one-metre distancing.
- ▶ Indoor and outdoor events will be limited to up to 100 people, based on one metre distancing, with people seated and separated for service of food and drink.
- ▶ Close-proximity businesses will be required to follow public health requirements in place.
- ▶ Tertiary education will be open on site with limited capacity based on one-metre distancing.

If My Vaccine Pass is not used, more severe restrictions will be imposed:

- ▶ Hospitality areas (for example, cafés, restaurants, and bars) will be contactless only.
- ▶ Gatherings at homes will be limited to up to 25 people.
- ▶ Other gatherings (such as weddings and tangihanga) and outdoor community events (with uncontrolled access) will be limited to up to 25 people, based on one-metre social distancing.
- ▶ Close-proximity businesses, indoor and outdoor events, and gyms cannot operate.
- ▶ Tertiary education will be by distance learning only.

2.6.4 Further actions

On 16 November 2021, the Government launched vaccine passes.¹²⁸ My Vaccine Pass is the official record of a person's vaccination status in Aotearoa New Zealand, which can be either printed or kept on a personal electronic device, and forms a key part of the Protection Framework.¹²⁹

On 17 November 2021, Prime Minister Ardern announced that Cabinet would 'confirm on November 29 its decision to move Auckland into the new traffic light

128. Submission 3.2.413(a), p 5.

129. 'About My Vaccine Pass', New Zealand Government, <https://covid19.govt.nz/covid-19-vaccines/covid-19-vaccination-certificates/my-vaccine-pass>, last modified 10 December 2021.

2.6.4

system which [was expected to] occur soon after the 29th.¹³⁰ The Prime Minister also indicated that Auckland would initially move into the red light. She confirmed that the rest of Aotearoa New Zealand would move into the Protection Framework at the same time as Auckland, and areas with lower vaccination rates would move into the red light. She stated that 82 per cent of residents of Aotearoa New Zealand were fully vaccinated and that it was expected the country would be at 90 per cent by mid-December.¹³¹

On 22 November, the Prime Minister announced that the whole country would move into the Protection Framework on 3 December 2021.¹³² A press release was issued on 29 November 2021, outlining the traffic light settings for each area of the country.¹³³

Under the Protection Framework, some restrictions would continue. For example, after Auckland shifted to the red light, travel was limited across the boundary in both directions.¹³⁴ However, between 15 December and 17 January 2022, people would be able to travel out of or into Auckland for any reason, provided they were fully vaccinated and carried their My Vaccine Pass or evidence of a negative COVID-19 test received within 72 hours prior to crossing the boundary.¹³⁵

In regard to the country's international borders, from January 2022, fully vaccinated members of the public could begin travelling to Aotearoa New Zealand.¹³⁶ The Government intends to manage this process in three stages and will allow the following groups to travel to Aotearoa New Zealand without entering managed isolation and quarantine:

- ▶ From 11:59 pm on 16 January 2022, fully vaccinated Aotearoa New Zealand citizens and other travellers eligible under the current Protection Framework settings could travel from Australia, provided they had been in Australia or Aotearoa New Zealand for the past 14 days.
- ▶ From 11:59 pm on 13 February 2022, fully vaccinated Aotearoa New Zealand citizens and other travellers eligible under the current Protection Framework settings could travel from all but very high-risk countries.¹³⁷

130. Right Honourable Jacinda Ardern, 'Auckland Boundary to Change 15 December', media release, 17 November 2021, <https://www.beehive.govt.nz/release/auckland-boundary-change-15-december>.

131. Ibid.

132. Submission 3.2.413(a), p 5.

133. Ibid.

134. 'Traffic Lights Map', New Zealand Government, <https://covid19.govt.nz/traffic-lights/traffic-lights-map>, accessed 2 December 2021.

135. Ibid.

136. 'Travel to New Zealand', New Zealand Government, <https://covid19.govt.nz/travel/international-travel-and-transit/travel-to-new-zealand>, last modified 3 December 2021.

137. The Government has created a 'very high risk' country category in order to significantly reduce the number of people with COVID-19 flying to New Zealand. The Government determines which countries are high risk on the following factors (among others): whether cases in the country are rising rapidly and the predominant strain there; the level of confidence in the country's testing and other public-health measures; and the risk to New Zealand's borders: 'Travel Restrictions for Very High Risk Countries', New Zealand Government, <https://covid19.govt.nz/travel/international-travel-and-transit/travel-restrictions-for-very-high-risk-countries>, last modified 29 November 2021.

- ▶ From 30 April 2022, fully vaccinated foreign nationals could enter Aotearoa New Zealand.¹³⁸

2.7 FUNDING PROVIDED TO ASSIST WITH THE COVID-19 RESPONSE FOR MAAORI

2.7.1 Te Arawhiti COVID-19 funding support

On 31 August 2021, the COVID-19 Ministerial Group approved a proposal to allocate \$1 million from Vote Te Arawhiti to resource iwi-led response planning, communications outreach, and support for the vaccine uptake.¹³⁹ Te Arawhiti then developed guidelines on how this funding was to be utilised to support iwi, and approved funding for the following activities:

- ▶ developing bespoke communications material, website updates, staffing for well-being calls around their community, particularly for elderly and vulnerable persons, and establishing 0800 phone numbers;
- ▶ developing communications material for community spokespersons, particularly for rangatahi, outreach to encourage and facilitate vaccinations, and organising vaccination logistics; and
- ▶ producing or updating iwi COVID-19 response plans particularly to cater to updated guidance on the Delta variant, including procuring specialist advice if required.¹⁴⁰

As at 11 October, Te Arawhiti had approved funding of \$1,215,000 to support 72 iwi groups (including six iwi collectives) with their COVID-19 pandemic response.¹⁴¹

2.7.2 Whaanau Ora

On 1 September 2021, Cabinet provided \$20.032 million of funding to the Whaanau Ora commissioning agencies to respond to the emergence of the COVID-19 Delta variant.¹⁴² Two tranches of \$8.861 million were allocated to three Whaanau Ora agencies for immediate response activities, with an additional \$5.4 million for exceptional support requirements.¹⁴³

2.7.3 COVID-19 Whaanau Recovery Fund 2021

On 8 September 2021, the Government reprioritised up to \$5 million dollars for the COVID-19 Whaanau Recovery Fund to provide immediate relief to vulnerable whaanau Maaori and communities during the COVID-19 outbreak. The initial

138. 'Travel to New Zealand', New Zealand Government, <https://covid19.govt.nz/travel/international-travel-and-transit/travel-to-new-zealand>, last modified 2 December 2021.

139. Document D46, p 11.

140. Ibid, pp 11–12.

141. Ibid, p 12.

142. Document D45, p 9.

143. Ibid, pp 9–10.

2.7.4

focus was on Taamaki Makaurau, Te Tai Tokerau, and Northern Waikato.¹⁴⁴ This fund was intended to be used to:

- ▶ support community-driven, local responses to gaps in access and provision of critical services;
- ▶ provide small grants to Maaori organisations and iwi working directly with the community; and
- ▶ support essential supplies and access to personal protective equipment, technology to help whaanau stay connected, transport to and from essential services, initiatives to support mental health, and the capacity and capability of Maaori organisations to build resilient communities.

To date, \$2.36 million has been invested, with the remaining money held as a reserve for future activity.¹⁴⁵

2.7.4 Vote Health funding for Maaori Development

On 28 September 2021, Te Puni Kookiri and the Ministry of Health sought approval for \$5 million from Vote Health to be re-allocated to Vote Maaori Development to increase the rate of vaccines amongst Maaori.¹⁴⁶ There was a particular focus in enabling further investment into Maaori pathways for vaccination by grassroots innovations. The \$5 million was invested as follows:

- ▶ \$500,000 to Wero-HIA (a programme run by the National Hauora Coalition) to boost vaccinations in Taamaki Makaurau. In particular, it was used to customise vaccination services to whaanau, come up with strategies to encourage whaanau to get vaccinated, and increase vaccinations over a seven-week period.
- ▶ \$3.5 million to Te Pou Matakana to boost vaccinations in Te Ika a Maui. In particular, kaupapa Maaori practices and principles were used to overcome physical and emotional barriers to vaccination in areas where vaccination rates are low.
- ▶ \$1 million on a regional vaccination programme which has invested in 27 projects across Aotearoa New Zealand. Examples of initiatives include the use of mobile units, information events, mass vaccination events and social media campaigns.¹⁴⁷

Many of these providers who received funding were then able to continue and expand activity following the announcement of the Maaori Communities COVID-19 Fund.¹⁴⁸

2.7.5 Maaori Communities COVID-19 Fund

On 22 October 2021, the Government announced the Maaori Communities COVID-19 Fund, a \$120 million fund to support Maaori communities to fast-track

144. Document D45, p 4.

145. Ibid.

146. Ibid, p 6.

147. Ibid, pp 6–7.

148. Ibid, p 7.

vaccination efforts and prepare for the COVID-19 Protection Framework.¹⁴⁹ The fund is administered by Te Arawhiti, Te Puni Kookiri, and the Ministry of Health and is overseen by a ministerial oversight group.¹⁵⁰ The fund is also designed for Ministers to review the settings and phasing of the fund, ensuring resources are applied to the most critical issues at the right time.¹⁵¹

The fund has a two-phase approach:

- ▶ Phase one (\$60 million) is dedicated to mobilising communities to connect whaanau to the vaccine and accelerate vaccine uptake, with a focus on removing barriers to vaccination and reaching ‘hard-to-reach’ areas.
- ▶ Phase two (\$60 million) is dedicated to increasing community resilience, ensuring access to information and resources, and supporting locally led and co-designed approaches to managing and minimising the impacts of COVID-19.¹⁵²

2.7.6 Ministry of Health funding

Since March 2020, the Ministry of Health has been distributing funding in order to support Maaori health and social service organisations to deliver the COVID-19 Maaori health response.¹⁵³ \$35.5 million distributed to date has been allocated as follows:

- ▶ \$11 million for vaccine readiness for providers;
- ▶ \$17.5 million for vaccine support services;
- ▶ \$5.6 million for a national support network, including with Whakarongorau (which is a telehealth service);
- ▶ \$1.4 million for local Maaori vaccine champions;
- ▶ \$2 million for local iwi and Maaori communications (including \$500,000 to be allocated by the Iwi Communications Collective); and
- ▶ \$1.5 million for Maaori workforce development and training.¹⁵⁴

In September 2021, a funding boost of \$36 million was set aside to provide additional support for Maaori health providers to respond to the Auckland, Northland and Waikato Delta outbreak. It comprised:

- ▶ \$13.57 million to help existing Maaori health providers adapt their services while maintaining essential business as usual;
- ▶ \$10.53 million to support broader iwi and Maaori providers to provide localised responses for whaanau, including increasing access to health services, medications, and hygiene products;
- ▶ \$5 million transferred to Te Puni Kookiri for Whaanau Ora network providers;
- ▶ \$3 million to be distributed by the Ministry’s Mental Health and Addiction Directorate to strengthen the Maaori psychosocial response; and

149. Ibid, p 10.

150. Ibid, pp 10–11.

151. Ibid, p 10.

152. Ibid, pp 10–11.

153. Document D48, p 26.

154. Ibid, pp 26–27, 28.

- ▶ \$4 million to ensure providers have sufficient funding to manage the long ‘tail’ of this outbreak, sustain their efforts, and build in contingency to help them prepare for future outbreaks.¹⁵⁵

2.8 THE PARTIES’ POSITIONS

2.8.1 The claimants’ and interested parties’ positions

The primary allegation of both the claimants and the interested parties was that the Crown’s vaccine rollout and rapid shift to the Protection Framework had failed Maaori.¹⁵⁶ This failure fell into three broad categories:

1. failure in relation to the vaccine rollout;
2. failure in the shift to the Protection Framework; and
3. failure in the Crown’s engagement with Maaori.

With regard to the vaccine rollout, we heard evidence that the Crown had failed in not prioritising Maaori so as to account for the disproportionate risk posed to them.¹⁵⁷ In addition, the vaccine rollout was characterised by the claimants and interested parties as badly communicated and designed so as to reinforce prejudice.¹⁵⁸ Parties argued that the vaccine rollout was unreflective of the advice received concerning it, if advice had been sought at all.¹⁵⁹ Overall, the parties argued that the sequencing framework was not developed in a way that gave effect to the Treaty principles.¹⁶⁰

In terms of the shift to the Protection Framework, the claimants and interested parties argued that the Crown had failed significantly and that this failure was avoidable. They noted that they offered advice on multiple occasions, and consistently throughout the course of the Delta wave, on how a shift to the Protection Framework should occur and when. This advice, the claimants and interested parties alleged, was ignored.¹⁶¹ In sum, they argued that the choice not to action their advice, and rapidly shift into the Protection Framework, indicated a critical failure on the Crown’s part to properly engage with Maaori and was inconsistent with the Treaty principles.¹⁶²

Finally, the claimants and interested parties pointed to what they saw as the Crown’s failure to engage with Maaori meaningfully throughout the course of the pandemic.¹⁶³ They identified numerous hui, groups, and plans that did not bring about tangible results. Multiple groups felt that consultation was a tick-box exercise, not intended to truly take advice on board. As such, the claimants and interested parties argued that the Crown did not adequately engage with Maaori on key

155. Document D48, p 28.

156. Submission 3.3.50, p 1.

157. Ibid; doc d2, pp 2–3; doc d39, p 23.

158. Submission 3.3.50; p 3; submission 3.3.54, pp 6–7.

159. Document D39, p 20.

160. Ibid, pp 24–25.

161. Submission 3.3.50, p 1; doc d11, pp 3–4; doc d39, p 28.

162. Submission 3.3.59, p 4; doc d32, p 9; doc d10, p 3.

163. Submission 3.3.50, pp 1–2; submission 3.3.57, p 12.

decisions in its pandemic response and, therefore, did not treat Maaori as a Treaty partner.

2.8.2 The Crown's position

Concerning the three failures which the claimants and interested parties' evidence focused on, which are outlined above, the Crown asserted:

1. numerous steps had been taken in relation to the vaccine rollout to account for Maaori;¹⁶⁴
2. decision-makers were highly conscious of the need to protect Maaori and were taking active steps to mitigate the risk to Maaori when shifting to the COVID-19 Protection Framework;¹⁶⁵ and
3. the Crown's consultation and engagement, both nationally and at a regional level, has been significant.¹⁶⁶

On the adequacy of the vaccination rollout and the COVID-19 Protection Framework, the Crown asserted:

1. Maaori health interests were central to the Crown's vaccination programme and sequencing framework;¹⁶⁷
2. the Government's decision to prioritise vaccinations on a 'risk and need' basis was a reasonable one and steps were taken in July 2021 to increase the vaccination uptake and conversion rates for Maaori;¹⁶⁸
3. the evidence demonstrated that the development and implementation of the COVID-19 Protection Framework had to move more rapidly than expected and that the Government was aware a shift to the new framework could have a disproportionate impact on Maaori, and there was therefore a need to consult with Treaty partners;¹⁶⁹ and
4. the shift to the COVID-19 Protection Framework would be more protective than the Alert Level Framework and decision-makers were highly conscious of the need to protect Maaori, consequently taking steps to mitigate the risk to Maaori.¹⁷⁰

On further broader issues, the Crown submitted:

1. its approach was consistently informed by health advice and modelling;¹⁷¹
2. the Government had to balance a range of factors and inputs in order to strike a reasonable balance in the particular circumstances, and that just because information or advice was not included in Cabinet papers, does not mean it was not taken into account;¹⁷²

164. Submission 3.3.58, p 2.

165. Ibid, p 14.

166. Ibid, pp 15–16.

167. Ibid, p 8.

168. Ibid, p 9.

169. Ibid, pp 11–12.

170. Ibid, p 14.

171. Ibid.

172. Ibid, p 15.

2.8.3

3. the Crown's consultation and engagement has been significant;¹⁷³
4. limitations in the collection of disability data impacted the ability to make targeted vaccination efforts or reliably track the rates of vaccination for disabled people;¹⁷⁴ and
5. it acknowledged the concerns that at times during the vaccination rollout that funding had been slow and that various bureaucratic processes were a barrier to efficient distribution of funds.¹⁷⁵

The Crown welcomed practical recommendations from the Tribunal to meet aims of increasing Maaori vaccination rates and building resilience in Maaori communities, in respect of the Maaori vaccination programme and the roll out of the Protection Framework.¹⁷⁶

The Crown submitted that there was a recognised need to protect Maaori from COVID-19, which had been taken into account in the vaccination rollout and the development and implementation of the COVID-19 Protection Framework.¹⁷⁷ The Crown acknowledged that some steps were taken that on their face, considering the variety of important considerations, did not appear to be the most protective for Maaori. However, in those circumstances additional protections had been put in place.¹⁷⁸

Crown counsel submitted that the Tribunal should focus on identifying immediate and practical steps the Crown might take. Despite maintaining that the Tribunal should not make findings in this report, the Crown said it would consider indications about tangible improvements that could be made in the absence of Treaty breach findings.¹⁷⁹

Regarding the Crown's compliance with Treaty principles, the Crown submitted that the Tribunal should be mindful of the circumstances in which COVID-19 pandemic response decisions were made – namely, during an urgent health crisis that required immediate action.¹⁸⁰

2.8.3 Crown witnesses

The following witnesses gave evidence on behalf of the Crown: the Right Honourable Christopher Hipkins, Dr Ashley Robin Bloomfield, Joanne Lisa Gibbs, John Whaanga, Lilian Marie Anderson, Grace Smit, Ruth May Fairhall, and George Osborne Whitworth.

173. Submission 3.3.58, p 15.

174. *Ibid*, p 16.

175. *Ibid*.

176. *Ibid*, pp 1–2.

177. *Ibid*, p 2.

178. *Ibid*.

179. *Ibid*, pp 5–6.

180. *Ibid*, p 7.

CHAPTER 3

THE CROWN'S TREATY OBLIGATIONS

3.1 JURISDICTION

The Treaty of Waitangi Act 1975 established the Waitangi Tribunal and confers its jurisdiction. Section 6 of the Act provides that any Maaori may make a claim to the Tribunal that they have been, or are likely to be, prejudicially affected by any legislation, policy, or practice of the Crown that is inconsistent with the principles of the Treaty. If the Tribunal finds that a claim is well founded, it may, having regard to all the circumstances of the case, make recommendations to the Crown to compensate for or remove the prejudice or to prevent others from being similarly affected in the future.

In this chapter, we summarise and develop the Treaty principles and standards established in *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* ('*Hauora*') and apply them to the issues identified in this priority inquiry. We also consider previous Tribunal jurisprudence on how Treaty principles and standards apply in times of crisis.

3.2 THE TREATY PRINCIPLES AND STANDARDS ESTABLISHED IN HAUORA

3.2.1 Tino rangatiratanga

Tino rangatiratanga means autonomy and self-government to the fullest extent possible.¹ The Treaty's guarantee of tino rangatiratanga provides for Maaori self-determination and mana motuhake in the design, delivery, and monitoring of health care.² Maaori are guaranteed tino rangatiratanga rights in respect of hauora Maaori, which encompasses Maaori organisations and their models of care, and Maaori people who need to access their services.³

The Crown is obliged to actively protect tino rangatiratanga. In the modern context, the Treaty's guarantee of tino rangatiratanga affords Maaori – through iwi, hapuu, or other organisations of their choice – the right to decision-making power over their affairs.⁴

The guarantee of tino rangatiratanga is not absolute and unqualified. While the Crown's obligation to uphold it is consistent, the Crown is not required to go

1. Waitangi Tribunal, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Lower Hutt: Legislation Direct, 2019), p 30.

2. Ibid, p 163.

3. Ibid, p 160.

4. Ibid, p 30.

beyond what is reasonable in the prevailing circumstances. What is reasonable is thus context-specific, and may change.⁵

3.2.2 Partnership

The principle of partnership is expressed through the necessary interplay between *kaawanatanga* and *tino rangatiratanga* expressed in articles 1 and 2 of the Treaty.⁶ The Treaty partnership is ‘a relationship where one party is not subordinate to the other but where each must respect the other’s status and authority in all walks of life’.⁷

The Crown and Maaori must work in partnership as co-designers of the governance, delivery, and monitoring of the health system and health services for Maaori.⁸ We emphasise that ‘co-design’ as a government process runs the risk of meaning something lesser in practice than the partnership guaranteed by the Treaty. It is thus vital that the design and provision of health and social services are founded in the Treaty partnership, in which the *tino rangatiratanga* and *mana motuhake* of Maaori must be fully recognised.⁹

The requirement for the Crown to partner with Maaori in developing and implementing policy is especially relevant where Maaori are expressly seeking an effective role in this process, and is heightened where disparities in outcomes exist.¹⁰

Because the power imbalance in the relationship favours the Crown, it is the Crown’s responsibility to ensure that Maaori are not disadvantaged in the Treaty partnership.¹¹

Any practical arrangement or framework intended to implement partnership requires constant evaluation to ensure it continues to meet Treaty obligations. In other words, a partnership arrangement that initially appears Treaty-consistent may prove otherwise in practice, and therefore require reconsideration and/or modification if the Crown is to continue fulfilling its Treaty obligations.¹²

3.2.3 Equity

The principle of equity is guaranteed by article 3, and requires the Crown to commit to achieving equitable health outcomes for Maaori.¹³ It is insufficient for the Crown to aspire only to reduce Maaori health disparities along with other population groups when Maaori suffer the worst health status of any population group

5. Waitangi Tribunal, *Hauora*, p 30.

6. *Ibid*, pp 27–28.

7. Waitangi Tribunal, *Te Whanau o Waipareira Report* (Wellington: GP Publications, 1998), p xxvi; Waitangi Tribunal, *Hauora*, p 28.

8. Waitangi Tribunal, *Hauora*, p 164

9. *Ibid*, p 142.

10. *Ibid*, pp 28–29.

11. *Ibid*, p 28.

12. *Ibid*, p 29.

13. *Ibid*, p 163.

in New Zealand.¹⁴ Equity of health outcomes is 'one of the expected benefits of the citizenship granted by the Treaty' and achieving this is dependent on the provision of state policies and services.¹⁵ For the Crown to satisfy its obligations under the principle of equity, it must both ensure Maaori do not suffer inequity, and also actively inform itself of the occurrence of inequity.¹⁶

Further, the principle of equity broadly guarantees freedom from discrimination, whether this discrimination is conscious or unconscious. Thus, the Crown is duty-bound to take active steps to address personal and institutional racism.¹⁷

However, in considering the obligations that the principle of equity places on the Crown in the present circumstances, we must acknowledge the complexity of health determinants and the multiplicity of agencies involved in addressing them. While Treaty principles require the Crown to work to the fullest extent possible towards achieving equity of socio-economic status for Maaori – and to be held to account by Maaori for its performance – we recognise that no single Crown entity or social sector agency can be accountable in isolation for achieving equity.¹⁸

3.2.4 Active protection

The principle of active protection also requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Maaori. The Crown must facilitate, and make available to Maaori, health services that are designed to close inequitable gaps in health outcomes with non-Maaori, regardless of the cause of those inequities.¹⁹ To this end, the Crown is required to focus specific attention on inequities experienced by Maaori, and keep itself informed of all relevant factors affecting Maaori needs.²⁰ The Crown, as well as its agents and delegates, must be well informed about the extent and nature of Maaori health outcomes and about efforts to achieve Maaori health equity. The Crown must also ensure its Treaty partner remains informed of and involved in this work.²¹

In informing itself of Maaori health status, the Crown cannot unilaterally determine what will be measured and how it will be reported. In other words, the Crown cannot be the sole auditor of its own performance – the Treaty obliges the Crown to ensure that the health system is accountable to its Treaty partner.²² In other words, the Crown cannot be the sole auditor of its own performance. The Treaty obliges it to ensure that both Treaty partners have equivalent ability to scrutinise the health system and hold it to account when it is not meeting Maaori

14. Ibid, p 96.

15. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p 64; Waitangi Tribunal, *Hauora*, p 34.

16. Waitangi Tribunal, *Hauora*, p 34.

17. Ibid, p 155.

18. Ibid, p 96.

19. Ibid, p 31.

20. Ibid, p 32.

21. Ibid, p 163.

22. Ibid, p 133.

3.2.5

needs. The Crown can discharge this obligation in many ways, including by publishing relevant data and information that allows Maaori to properly monitor and assess the Crown's legislation, policy, actions, and omissions.²³

If need be, the Crown must provide additional resources to address the causes of inequities, and implement other positive steps towards addressing them. This is particularly urgent when Maaori interests and rights derived from the Treaty are under grave threat.²⁴

As the Tribunal said in *Tuu Mai te Rangi!*, if the Crown fails to discharge its duties to actively protect Maaori rights and interests, that 'is as much a breach of the Treaty as the active removal of those rights'.²⁵

3.2.5 Options

The principle of options requires the Crown to provide for and properly resource kaupapa Maaori health services. Furthermore, the Crown is obliged to ensure all health services are provided in a culturally appropriate way that recognises and supports the expression of hauora Maaori models of care.²⁶

The Crown has an active duty to ensure that both kaupapa Maaori and mainstream health care service providers are guaranteed equal Treaty protection.²⁷ The Crown is responsible for ensuring Maaori are not disadvantaged by their choice of health service, and any option which is offered should be well supported.²⁸

3.3 THE CROWN'S TREATY OBLIGATIONS IN A NATIONAL HEALTH CRISIS

We noted in *Hauora* that the Crown's kaawanatanga rights include the power to 'govern and make laws for the country', subject to its other Treaty obligations.²⁹ Previous Tribunal reports, including *Hauora*, have emphasised that while the Crown must take the limits of kaawanatanga and its corresponding Treaty obligations seriously, what might constitute reasonable conduct is moderated by the circumstances of the time. In fact, and particularly in modern times, what is 'reasonable' in a crisis may require the Crown to act much more decisively and proactively, and with much greater consideration of its Treaty obligations, in order to address the increased burden on Maaori as a result of the inequities they experience as a result of the crisis.

The Treaty's guarantees are enduring, and, as Crown counsel acknowledged, the Crown is obliged to take them into account at all times.³⁰ As *He Maunga Rongo* (2008) found, in times of crisis, the Crown must weigh up priorities when

23. Waitangi Tribunal, *Hauora*, pp 129, 132–133.

24. *Ibid*, p 32.

25. Waitangi Tribunal, *Tuu Mai te Rangi! Report on the Crown and Disproportionate Reoffending Rates* (Lower Hutt: Legislation Direct, 2017), p 22; Waitangi Tribunal, *Hauora*, p 31.

26. Waitangi Tribunal, *Hauora*, p 163.

27. *Ibid*, p 35.

28. *Ibid*, p 35.

29. *Ibid*, p 28.

30. Submission 3.3.58, para 23.

considering its Treaty obligations.³¹ But in the same report, the Tribunal also cautioned that the Crown cannot weigh up its priorities 'without restraint'.³² In other words, the weighing up itself must be Treaty compliant. Commenting specifically on environmental policy, that report identified circumstances where the Crown's Treaty obligations in respect of another more pressing issue or serious threat should be prioritised over Maaori Treaty interests in environmental policy.

In a health crisis, the Crown's Treaty obligations in respect of health should be prioritised. This might mean its Treaty obligations in respect of the environment, for example – while still in effect – are less of a priority for its focus and resources. The more pressing or threatening the issue is in general, the more pressing or threatening it is to Maaori specifically – and thus, the more important it is for the Crown to uphold its Treaty obligations when responding to a crisis. In a crisis, what is in the national interest must also, by definition, be in the Maaori interest.

As such, the prioritisation of the Crown's Treaty obligations in times of crisis should not be misunderstood as allowing the Crown to disregard some obligations in favour of other interests. Instead, the Crown must consider what Treaty interests are particularly pressing in the circumstances, including those that may be heightened.

To that end, *He Maunga Rongo* identified 'public welfare and safety' as one of the paramount considerations – along with 'war or impending chaos' – that may justify giving priority to a particular Treaty interest (or interests) out of the multiple interests the Treaty obliges it to inform itself of and actively protect. The prioritisation at play in the COVID-19 crisis is this: the Crown's Treaty obligations in respect of its response to the pandemic are heightened due to the threat posed to the welfare and safety of Maaori and other citizens.

We do not discount that there may be a limited set of circumstances in which, accounting for all possible factors, the threat to public welfare or safety is sufficiently serious to justify the Crown moving urgently – and, in doing so, it may fall short of what would normally be expected of it to satisfy its Treaty obligations. This point was made on behalf of the New Zealand Maaori Council. But we emphasise that – given the centrality of joint decision-making and engagement to the Crown's obligations under the Treaty principles of *tino rangatiratanga*, partnership, equity, active protection, and options – the threshold that might justify such a move is high.

Although it was not the focus of the evidence before us in this inquiry, we observe that the first lockdown in March 2020 seems relevant here. The first Alert Level 4 lockdown immediately suspended *tikanga*, in particular by forbidding *tangihanga*. Maaori communities were thus forced to significantly adjust their usual customary laws and practices, not by choice but as a result of Government policy. The ability of Maaori to practice *tikanga* undisturbed by Crown intervention is guaranteed in the Treaty. Nonetheless, we note that there appeared to be

31. Submission 3.3.58, para 23.

32. Waitangi Tribunal, *He Maunga Rongo: Report on Central North Island Claims, Stage One*, revised ed, 4 vols (Wellington: Legislation Direct, 2008), vol 4, pp 1238–1240.

some tolerance amongst Maaori for the move to Alert Level 4, given the circumstances, even though the move occurred without the consultative processes or engagement that would usually be expected.

This tolerance, we observe, was likely in part informed by Maaori memory of the Spanish Flu Pandemic of 1918, and other epidemics. Maaori brought that memory and tikanga into their decision-making, and their framework of expectations for Crown conduct. Intuitively, Maaori knew the potential cost to their communities of an unchecked pandemic would be devastating, and that it would evoke scenes from the past.

This memory also informs Maaori expectations of the Crown's conduct now. The present pandemic is a national health crisis of a magnitude that should focus and heighten the Crown's efforts to actively address any inequities suffered by Maaori in accordance with Treaty principles. This is particularly so because, as the Crown acknowledged both in stage one and in this inquiry, Maaori are at greater risk due to current health inequities, and because Maaori-designed and Maaori-delivered community health responses have proven to be effective.³³

We emphasised in *Hauora* the serious and far-reaching obligations the Crown has to ensure that Maaori are able to sustain their health and well-being. In establishing what might be a reasonable threshold for the Crown's obligation to actively protect Maaori to the fullest extent practicable, we note that other Tribunal reports have considered the Crown's obligations during other health crises (for example, the Spanish Flu Pandemic of 1918) and what the Crown could reasonably have achieved at the time, given its knowledge and resources.³⁴

However, in the twenty-first century, advances in medicine and the Crown's increased ability to move quickly to address health crises both magnify what it can and should do to meet its obligations to actively protect Maaori to the fullest extent practicable. We are mindful, therefore, that the claim and evidence before us allege substantial existing and likely prejudice as a result of COVID-19, and particularly the Delta variant. We consider this means the heightening of the Crown's Treaty obligations is reasonable in the circumstances.

We are also mindful of the article 2 guarantee of Maaori tino rangatiratanga in respect of their people and communities.³⁵ As we said in *Hauora*, Maaori having adequate decision-making power is essential to achieving health equity.³⁶ Given the expansive kaawanatanga powers exercised in this emergency and the need for agile decision-making by the Executive, the Crown's obligation to actively protect tino rangatiratanga and partner with Maaori is, in fact, intensified.

For all these reasons, the Crown's Treaty obligations, and especially its obligation to actively protect Maaori to the fullest extent practicable, are perhaps more imperative now than at any other time in recent history.

33. Submission 3.1.155, para 1.11; Waitangi Tribunal, *Hauora*, pp 20–21.

34. Waitangi Tribunal, *Te Mana Whatu Ahuru: Report on Te Rohe Pootae Claims*, 6 vols (Lower Hutt: Legislation Direct, 2023), vol 5, pp 2859–2864, 2892–2893.

35. Waitangi Tribunal, *Hauora*, p 160; Waitangi Tribunal, *He Paaharakeke, he Rito Whakakiikinga Whaaruarua* (Lower Hutt: Legislation Direct, 2021), p 12.

36. Waitangi Tribunal, *Hauora*, pp 158, 160.

CHAPTER 4

ANALYSIS AND FINDINGS

4.1 THE COVID-19 VACCINE ROLLOUT

4.1.1 The need for a prioritised vaccine rollout

The vaccine sequencing framework was designed according to the relative risks COVID-19 posed to different sectors of Aotearoa New Zealand's population. For the purposes of this inquiry, the key issue arising from the development of the vaccine sequencing framework is the way that Maaori, as a priority group under the vaccine strategy and as a population group more likely to suffer adverse health outcomes as a result of infection, were prioritised to take account of the disproportionate risk they faced.

The evidence before us shows it was reasonable for the Crown to prioritise vaccine availability due to logistical challenges. Joanne Gibbs, national director of the COVID-19 vaccine and immunisation programme at the Ministry of Health, told us that although the Government purchased enough Pfizer vaccines for the country's population, supplies were initially limited. Strict storage and low-temperature refrigeration requirements for the Pfizer vaccine, which were later relaxed, also initially constrained vaccine availability.¹ As such, the Crown was required to develop a 'sequencing framework' that would prioritise certain groups.² The framework was also designed to account for disease prevalence in Aotearoa New Zealand.³

Between August 2020 and March 2021, the Ministry of Health developed and Cabinet approved an approach whereby the population over the age of 16 would be prioritised into the following groups:

- ▶ Group 1: border and MIQ workforce, and their household contacts;
- ▶ Group 2: frontline workers and people living in high-risk settings, including people in long-term residential care and people living in Counties Manukau District Health Board who had certain health conditions or are 65 years or older;
- ▶ Group 3: people at higher risk of poor health outcomes such as older people and people with certain health conditions or disabilities; and

1. Document D48, pp 5–6.

2. Ibid.

3. Ibid.

4.1.2

- ▶ Group 4: the remainder of the general population.⁴

Ultimately, in February 2021, when Group 1 started receiving the vaccine, Aotearoa New Zealand was in a position of low to no community transmission of COVID-19.⁵

4.1.2 Cabinet is advised to approve an age adjustment for Maori to achieve an equitable vaccine rollout

The Crown officials who appeared before us emphasised that their aim was to design and implement a vaccine rollout that was equitable, including for Maori.

This key goal underpinned the Ministry of Health's own assessment of how each priority group should be defined, which began in 2020. The Ministry received independent scientific and technical advice on factors to use when defining priority groups, including 'those at risk of spreading COVID-19, those at risk of contracting COVID-19 and those at highest risk of increased morbidity and mortality associated with COVID-19'.⁶

The claimants and interested parties called as witnesses some of the experts who informed the Ministry of Health's assessment. In his evidence, mathematical modeller Professor Shaun Hendy described the advice his organisation Te Puunaha Matatini had provided the Ministry, which clearly outlined the importance of accounting for ethnicity in the vaccine rollout. Following the March-April 2020 and August-September 2020 outbreaks, Te Puunaha Matatini conducted two studies which attempted to estimate the impact of COVID-19 by ethnicity.⁷ The findings indicated that Aotearoa New Zealand's response should 'include a focus on measures to protect high-risk groups and to prevent the large-scale inequities in health outcomes'.⁸ Findings also showed Maori had a 2.5 times greater likelihood of hospitalisation than non-Maori, non-Pacific, people. This meant that a 59-year-old Maori patient with COVID-19 and no co-morbidities had the same risk of hospitalisation as an 80-year-old Paakehaa.⁹ The report and its recommendations were made available to the Ministry of Health in October 2020.

4. Document D48, p 5; Ministry of Health, 'Update on COVID-19 Immunisation Strategy and Programme', draft Cabinet paper, 12 November 2020, <https://covid19.govt.nz/assets/Proactive-Releases/proactive-release-2021-november/Draft-Cabinet-paper-Update-on-COVID-19-Immunisation-Strategy-and-Programme-20201926.pdf>; Honourable Chris Hipkins, Honourable Andrew Little, and Honourable Dr Ayesha Verrall, 'Update on the COVID-19 Immunisation Strategy and Programme', [December 2020], https://www.health.govt.nz/system/files/documents/information-release/update_on_the_covid-19_immunisation_strategy_and_programme_december_2020.pdf; Michael Webster, 'Update on the COVID-19 Immunisation Strategy and Programme', Cabinet minute of decision, CAB-20-min-0509, 7 December 2020, https://www.health.govt.nz/system/files/documents/information-release/cab-20-min-0509_0.pdf; Dr Ashley Bloomfield, 'February 2021 Update on the COVID-19 Immunisation Strategy and Programme', draft Cabinet paper, 15 January 2021, https://www.health.govt.nz/system/files/documents/information-release/15_january_2021_draft_cabinet_paper_february_2021_update_on_the_covid-19_immunisation_strategy_and_programme.pdf.

5. Document D48, p 5.

6. Ibid, p 6.

7. Document D23, pp 3-4.

8. Ibid, p 4.

9. Ibid.

Statistician Andrew Sporle also stated that, throughout 2020, modellers and researchers had provided the Ministry of Health with multiple reports emphasising the severe inequitable impact the pandemic would have, unless Cabinet adopted a vaccination strategy that prioritised Maaori.¹⁰

In part informed by this expert advice, Crown officials were also of the view that an equitable vaccine rollout would need to expressly target the Maaori population. In particular, the Ministry noted, in its development of the sequencing framework in December 2020, that the expert advice was:

there is a high level of evidence that there is high strength of association between COVID-19 infections and transmission, and population groups with shared sleeping and living arrangements. There was also a high level of evidence that there was a high strength of association between severe disease from COVID-19 and population groups who [have] prior existing conditions (including coronary heart disease, hypertension and respiratory disease).¹¹

As the parties agreed in the statement of facts, all these factors are disproportionately characteristic of the Maaori population when compared with other population groups.

Dr Rawiri Jansen noted that the Government's COVID-19 Immunisation Implementation Advisory Group advised against a sequencing based on age and emphasised the potential disparities of a one-size-fits-all model which would put Maaori at risk. The group also noted that using 65 as a cut-off had no scientific grounding.¹² Dr Jansen observed that the group's advice was based on scientific evidence:

The science said very clearly that Maaori are at risk from the age of 44 in an equivalent way to a 65 year old Paakehaa man. This [younger] age group should therefore have been prioritised in the vaccine rollout. This was a critical piece of advice, strongly supported by the IAG and reiterated several times to the Ministry.¹³

Dr George Laking also provided evidence on the advice given by Maaori leadership organisations including Te Roopuu Whakakaupapa Urutaa, Te Ohu Rata o Aotearoa, and the New Zealand Maaori Council on COVID-19 immunisation for Maaori.¹⁴ Dr Laking referred to the report of the National Ethics Advisory Committee, published by the Ministry of Health in February 2021.¹⁵ The report provided a framework to assist Cabinet with the ethical implications of resource allocation and to ensure te Tiriti principles were embedded within the decision-making process. The committee clearly outlined the risk posed to Maaori:

10. Ibid, p 2.

11. Document D48, p 7.

12. Document D39, p 19.

13. Ibid, p 20.

14. Document D24, p 3.

15. Ibid.

As such, the relationship between age and COVID-19 may be different for Maaori and potentially affect the population younger than other populations. In addition, Maaori households often have more people than the New Zealand average, which places more people at risk from exposure to infectious diseases – but, conversely, more people in the household stand to benefit from preventative actions. The COVID-19 response should aim to avoid exacerbating existing inequities; solutions to address historical injustices are still required.¹⁶

The committee also advised that: ‘Age should not be used to categorically exclude individuals from standard-of-care therapeutic interventions; nor should specific age-based cut-offs be used in allocating resources.’¹⁷

In January 2021, the Ministry’s further assessment of evidence of an increased COVID-19 risk to Maaori noted ‘the (then) recent report by Te Puunaha Matatini finding Maaori were 2.5 times more likely to be hospitalised than other New Zealanders (after controlling for age and pre-existing conditions)’.¹⁸

The Ministry’s subsequent recommendation to Cabinet in March 2021, as confirmed by Joanne Gibbs and Dr Ashley Bloomfield, was ‘that while it was difficult to precisely determine the differential health impact of COVID-19 on Maaori and Pacific peoples, . . . a risk adjustment of 15 years [should] be applied to Maaori and Pacific people in the roll-out of the vaccine to older people in Group 3.’¹⁹

Under cross-examination, Ms Gibbs was asked why Professor Hendy’s advice that any age adjustment should be 25 years was not taken up. She replied:

In terms of the advice where we landed the 15 years, I think I would want to say that that wasn’t exclusively on the feedback of Shaun Hendy. We took feedback from a whole range of different groups and scientific advice taking into account not just as Ashley described the long-term conditions but also people that were at the most risk from a socio-economic and cultural point of view. In order to come up with that, that was advice from our own Immunisation Implementation Advisory group, from CVTAG, from the National Ethics Advisory Committee and from Te Puunaha Matatini.²⁰

We are not in a position to determine whether the advice provided to Cabinet on age adjustment was the ‘right’ recommendation. What is more important is that we heard repeatedly from witnesses including public health experts, Maaori service providers, iwi leaders, and the Crown’s own officials from Te Puni Kookiri, Te Arawhiti, and the Ministry of Health that an age adjustment for Maaori would be a clear, equitable, and proportionate measure for the vaccine rollout. We are satisfied, given the range of expertise and the clear agreement between the witnesses

16. Document D24(a), p 44.

17. Ibid, p 74.

18. Document D48, pp 7–8.

19. Ibid, pp 8–9; transcript 4.1.10, p 394.

20. Transcript 4.1.10, p 424.

who appeared before us, that the advice provided was on the basis that an age adjustment would have actively protected Maaori health and well-being.

We are also satisfied that any age adjustment for the rollout would not have disadvantaged other population groups due to limited supply or storage constraints. By the time the general population began to become eligible based on their age, starting in Group 3 with over-65s in around May 2021, the limitations due to cold storage requirements were no longer a factor, and the vaccine was by then much more widely available.²¹ Further, by July 2021 district health boards had the infrastructure required to deliver between 40,000 and 50,000 vaccinations per day – the required amount to ensure vaccinations could be provided to all eligible New Zealanders by the end of 2021.²²

4.1.3 Cabinet instead approves a ‘whaanau-based approach’

Despite the February 2021 advice provided to approve an age-adjusted rollout for Maaori and other population groups, Ms Gibbs and Dr Bloomfield told us that Cabinet instead adopted a ‘whaanau centred approach, prioritisation of 40,000 courses of vaccine to be allocated to Maaori and Pacific providers to begin early roll out for their vulnerable populations and continuing access of those providers to ongoing supply for Group 3.’²³ This approach aimed to ‘deliver a Programme that is effective, equitable, and upholds the principles of Te Tiriti.’²⁴ Ms Gibbs also emphasised the importance placed upon empowering iwi, whaanau, hapuu, and communities to design and lead their own response, commenting that: ‘Investment in by Maaori, for Maaori is a vital part of the COVID-19 vaccination rollout programme and has been successful.’²⁵

In his evidence, Dr Rawiri Jansen speculated about what the Government’s approach for Group 2 was intending to do:

Group 2 covered those people in long-term residential [care] and these people are likely to be disproportionately Paakehaa. It also included older people living in a whaanau environment and those they live with, as they face a similar risk to those in aged residential care. The Government then allocated an additional 40,000 vaccines to Maaori and Pacific providers to support this group.²⁶

However, he told us he was sceptical that either of these approaches would be effective proxies for inequity:

it was not clear what ‘a similar risk’ to aged residential care would be and with additional courses provided, this group would largely be Paakehaa. The additional allocation was an attempt to mitigate some of the inequity by vaccinating whaanau in a

21. Document D48, p 12.

22. Ibid, p 13.

23. Transcript 4.1.10, p 389.

24. Document D48, p 11.

25. Ibid, p 29.

26. Document D39, pp 23–24.

household with kuia and koroua, however it encouraged Maaori and Pacific providers to operate on an agenda that could disrupt the public health campaign which was challenging to implement given the logistical constraints of the Pfizer vaccine.²⁷

Regardless of intent, we heard evidence from providers who did not have the capacity to adopt the Government's whaanau-centred approach. Indeed, there was little mention by either claimants or interested parties of the Government's whaanau-based approach, except to indicate its absence in the early stages of the vaccine rollout.²⁸ Further, the limit on supply during the first months of the rollout frustrated those who did attempt to leverage the approach. Mr Colquhoun and Ms Cunningham told us that due to the cold-storage requirements early on in the vaccine rollout, Te Puna Ora o Mataatua, a Maaori health provider, was only given 30 vaccine doses per day, which was, an 'insufficient number of vaccines to meet demand'. They told us that due to these constraints, they were forced to turn away eligible whaanau who wanted to get vaccinated.²⁹

We were told that the whaanau-based approach, as well as a loose definition of 'long-term conditions' under Group 2, were relied on as a way of making sure many Maaori were eligible to be vaccinated earlier in the rollout.³⁰ We are not so convinced that either approach was effectively communicated to Maaori, and therefore whether Maaori were aware that their whaanau were eligible to take up the vaccine. Indeed, the clear rules around a strict age-based rollout and the complementary 'whaanau-based approach' and looser definition of long-term conditions appear to us to be in contradiction. This was confirmed in Crown evidence, with Ms Gibbs acknowledging that the '[t]ake-up of the whaanau-based approach appeared slow, possibly due to predominant message of the age-based approach.'³¹ On whether the prioritisation of people with long-term conditions in Group 2 was effective at capturing Maaori, Ms Gibbs' evidence revealed that the approach 'had been an imperfect vehicle to target the population with long-term conditions, with some people with eligible conditions not easy to identify and others slow to come forward as they were not over 65.'³²

The chief executive of Te Arawhiti, Lil Anderson, described the role of Te Arawhiti as facilitators of the engagement between lead agencies and Maaori in the COVID-19 response. She told us that Te Arawhiti 'emphasised the negative consequences for Maaori of the Crown's own modelling.'³³ Ms Anderson's evidence outlined that Te Arawhiti had provided commentary on draft Cabinet papers to this effect:

27. Document D39, p 24. Ms Gibbs said that, at the time that the definition for Group 2 added people living in long-term residential care, 'it was acknowledged that Maaori and Pacific peoples are less likely to live in residential care' (doc d48, p 9).

28. See, for example, doc d44, p 9.

29. Document D43, para 53.

30. Transcript 4.1.10, pp 389, 413-414.

31. Document D48, p 25.

32. Ibid, p 10.

33. Transcript 4.1.10, p 491.

In August 2021, Te Arawhiti provided comment on the 'Progress of the COVID-19 Vaccine and Immunisation Programme', a draft Cabinet paper providing an update on progress of the vaccine rollout and seeking decisions on vaccine delivery profiles.

Te Arawhiti commented that the paper should address the emerging equity issues in the rollout, what was being done to investigate and rectify the situation, and what engagement had occurred. . . .

On 15 October 2021, Te Arawhiti provided comments . . . on the draft 'Reconnecting New Zealanders' Cabinet paper. Our main stated concern was that the paper did not adequately acknowledge the differential impact on Maaori from the opening up activities proposed. Te Arawhiti recommended strengthening the paper by explicitly noting that low vaccination rates and higher co-morbidity of Maaori meant that taking on additional risks by opening up were very likely to impose a heavier health burden on Maaori.³⁴

4.1.4 The Government increases funding for the vaccine rollout

As covered in chapter 2, the Government made some funding available to assist Maaori with the Maaori vaccination effort. Prior to September 2021, \$35.5 million was distributed to equip Maaori providers for delivering vaccines. It was used for things like training, coordination, and the development of infrastructure.³⁵

After the Delta outbreak in Auckland, the following additional funding was made available:

- ▶ on 31 August 2021, the COVID-19 Ministerial Group approved a proposal to allocate \$1 million from Vote Te Arawhiti to resource iwi-led response planning, communications outreach, and support for the vaccine uptake;³⁶
- ▶ on 1 September 2021, Cabinet agreed to provide \$20.032 million of funding to the Whaanau Ora commissioning agencies to respond to the emergence of the COVID-19 Delta variant;³⁷
- ▶ on 8 September 2021, the Government reprioritised up to \$5 million for the COVID-19 Whaanau Recovery Fund to provide immediate relief to vulnerable whaanau Maaori and communities during the COVID-19 outbreak, with an initial focus on Taamaki Makaurau, Te Tai Tokerau, and Northern Waikato;³⁸ and
- ▶ on 28 September 2021, \$5 million was transferred from Vote Health to Vote Maaori Development for Maaori vaccination efforts, which went to the National Hauora Coalition, Te Pou Matakana (the Whaanau Ora Commissioning Agency), and 27 other projects.³⁹

From September 2021, \$36 million of additional funding was made available to support providers with matters other than vaccinating, primarily to support Maaori health providers to respond to the Auckland, Northland, and Waikato

34. Document D46, pp 7–8.

35. Document D48, pp 26–27.

36. Document D46, p 11.

37. Document D45, p 9.

38. *Ibid*, p 4.

39. *Ibid*, p 6.

Delta outbreaks. It went towards Whaanau Ora network providers; the Ministry of Health's Mental Health and Addiction Directorate; increasing staffing and contingency planning for Maaori providers; and into a \$10.53 million fund that allowed Maaori providers to apply for support to 'provide localised responses for whaanau, including increasing access [to] health services, medications, and hygiene products'.⁴⁰

Most of this funding was provided after Delta had already begun spreading in the community. As such, claimants told us it was not provided in time to sufficiently uplift the Maaori vaccination rate, as it takes time between funding being made available and it actually reaching providers.⁴¹

Taangata turi and whaanau hauaa providers told us that they had also found it difficult to secure funding.⁴² Haamiora (Sam) Te Maari informed us that extra funding for New Zealand Sign Language was required, as taangata turi are unable to access any services or funding without it.⁴³ Likewise, Karen Pointon stated that the lack of available health data on their community makes it difficult to secure funding for projects.⁴⁴ Tania Kingi, a witness for Te Roopuu Waiora, stated that she thinks they are at a disadvantage because of the way they have been grouped with other disability care organisations:

When we had our own contract with the Ministry, we wrote our reports around the experiences of whaanau hauaa. In the situation that we're in now, we write the reports, they are combined with 20 other Paakehaa organisations into one report, we don't get to see that report and it is sent to the Ministry. Any issues that we may raise about our community, it gets assimilated and diluted in that process.⁴⁵

It seems this funding was provided to improve Maaori vaccination rates, which by August and September were well behind the general population. But the injection of funding was not enough to remedy the pre-existing disparities between Maaori and non-Maaori vaccination rates. Further, as established earlier, it may not have been necessary for the Crown to adopt this funding effort late in the process and during an outbreak, if it had adopted an age adjustment in the vaccination rollout when setting its policy in early 2021.

4.1.5 The data informing the vaccine rollout

According to Ms Gibbs, 'data has been an essential enabler to guide vaccination activity and monitor success'.⁴⁶ Witnesses for all parties identified the lack of accurate, robust data on Maaori, particularly taangata whaikaha, as a particular concern.

40. Document D48, p 28.

41. Document D16, pp 9–10.

42. Documents D5, D29, D30.

43. Transcript 4.1.10, p 254.

44. Document D29, pp 4–5.

45. Transcript 4.1.10, p 268.

46. Document D48, p 31.

4.1.5.1 *Ethnicity data*

To calculate the vaccination doses the programme required, the Ministry's vaccination programme used the Health Service User dataset, which incorporates the Ministry's 11 national datasets to create a 'denominator for the eligible population in each district health board area in New Zealand at an individual level by age and ethnicity'.⁴⁷ Both Ms Gibbs and Dr Bloomfield emphasised the value of the dataset as, by capturing people's National Health Index numbers, it allows the Ministry to 'identify and track individuals down at a very granular level' and target efforts accordingly.⁴⁸

However, Dr Bloomfield and Ms Gibbs also acknowledged that the dataset undercounts Maaori compared with the census count.⁴⁹ Statistician Andrew Sporle confirmed that the Ministry of Health had long recognised Maaori were being undercounted because the dataset consisted only of those who interacted with healthcare in 2020, and Maaori are much less likely to access health care.⁵⁰ Mr Sporle estimated the undercount at 74,244 people, based on Statistics New Zealand's official population estimates for December 2020.⁵¹

4.1.5.2 *Ethnicity and social determinants*

Mr Sporle explained that the people who are disengaged from health services and, therefore, undercounted in this dataset, are likely to have a higher risk profile.⁵² These people are more likely to be young, male, have larger social networks, and live in small 'towns without strong social or health services and towns with large unemployment rates, or in the case of South Auckland, really mobile marginalised populations'.⁵³ Based on these factors, these people have a far greater chance of spreading or contracting the virus. A high proportion of these 'disengaged' people will be Maaori due to their age and geographic distribution. As such, their exclusion from the data has a 'potentially devastating impact' on the effectiveness of the Maaori vaccination rollout.⁵⁴

In addition, undercounting these Maaori means that the Ministry of Health is unlikely to have an accurate understanding of Maaori vaccination rates.⁵⁵ Dr Bloomfield disputed this, and said that the Ministry's estimates of Maaori vaccination coverage may actually be 'lower than what it would be if we . . . use the Statistics New Zealand denominator', because the Health Service User dataset may be undercounting Maaori due to misclassification in a different ethnic group which has higher vaccination rates.⁵⁶

47. Ibid.

48. Transcript 4.1.10, p 387; doc d48, p 31.

49. Transcript 4.1.10, p 387.

50. Document D3, p 3.

51. Ibid.

52. Document D3(a), pp 39–40.

53. Transcript 4.1.10, p 334.

54. Document D3(a), p 39.

55. Transcript 4.1.10, p 328.

56. Ibid, p 387.

4.1.5.3

Crown counsel told us that work had commenced on improving health data quality through the development of Statistics New Zealand's Integrated Data Infrastructure, which Mr Sporle explained is a database of 25 data sets that is 'the digital footprint of interactions with the Crown'.⁵⁷ Crown counsel submitted that in using the Integrated Data Infrastructure, Maaori would still be captured 'somewhere else . . . most likely under European or one of those other categories'.⁵⁸ Therefore, while Crown counsel 'accept[ed] the inadequacies of the data as it stands', like Dr Bloomfield, they stated the undercounted people have not 'fallen completely off the data pool'.⁵⁹

However, Mr Sporle stated that, even if this is the case, '(a) the Ministry is breaching its own data quality protocols . . . and (b) that means that they are not actually collecting robust data to inform an equitable and protective response'.⁶⁰ He further observed that 18 months into a pandemic is far too late for the Crown to start trying to identify where Maaori might have been misidentified in their own datasets.⁶¹

As he explained, without a detailed and accurate understanding of Maaori vaccination rates, the Ministry cannot have 'a clear picture of what resources are required' at both a national and local level.⁶² In addition, the undercount affects any assessment of the success of the vaccination programme for Maaori. He said that once the significant number of Maaori unrepresented in the dataset is accounted for, the actual vaccination rate for Maaori was 'significantly lower' and 'a much higher number of vaccinations [had] to be delivered to reach a 90% vaccination coverage for Maaori'.⁶³ He also noted that undercounting has serious implications for the health system's ability to plan for and respond to the impact of long COVID, which puts people at greater risk of 'severe chronic conditions'.⁶⁴ Indeed, age groups with the lowest vaccination rates (12–19 and 20–34 years) constitute 38.4 per cent of the Maaori population.⁶⁵

4.1.5.3 Disability data

Witnesses for all parties told us that there were even more significant problems with the data on taangata whaikaha, both Maaori and non-Maaori. Ms Gibbs acknowledged that 'Information on the disabled population has proved to be a significant constraint on the Programme with available data only able to identify approximately 40,000 out of an estimated 1.1 million disabled people (or 600,000 people between ages of 16–64)'.⁶⁶

57. Transcript 4.1.10, p 337.

58. Ibid, pp 337–338.

59. Ibid, p 338.

60. Ibid.

61. Ibid.

62. Ibid, p 329.

63. Document D3, p 3.

64. Transcript 4.1.10, p 335.

65. Document D3(a), p 39.

66. Document D48, p 33.

Tania Kingi said insufficient data had exacerbated the barriers faced by taangata whaikaha during the pandemic.⁶⁷ While the Crown included whaanau hauaa and those with a disability in Groups 2 and 3 of the rollout, the only available records capturing whaanau hauaa vaccination rates were for those who received funded support – which excluded many whaanau.⁶⁸

Likewise, Karen Pointon told us that:

The Government does not seem to collect data on the Taangata Turi population or their vaccination status. This is a problem, especially during a pandemic, as it is impossible for us to know the number of Turi whaanau that we need to reach with COVID-19 related information and those we need to encourage to get vaccinated.⁶⁹

Ms Gibbs said that further work is being done by the Ministry and the Social Wellbeing Agency to utilise data in the Statistics New Zealand Integrated Data Infrastructure database, which brings together census, sample survey, and needs-assessment data, to better understand vaccine uptake for disabled people.⁷⁰ For disabled children and youth, Ms Gibbs said that a data-sharing arrangement is being negotiated with the Ministry of Education to support targeted outreach to students who the Ministry of Education funds as Ongoing Resource Students and High Health students.⁷¹

4.1.6 Was the vaccine rollout Treaty-compliant?

First, the issues highlighted by the Crown's incomplete data collection is clearly a barrier to an effective vaccine rollout. Witnesses from all parties told us that insufficient data collection and organisation was hampering the vaccination effort. We agree with Mr Sporle that, while the Crown is now working to improve the way its data is organised, they have started this work much too late. Indeed, in stage one we similarly noted issues with the data collected by the Ministry for the primary care sector, and found them in breach of the Treaty.⁷²

We find that the Crown does not collect sufficient data to accurately and equitably inform the rollout of the vaccine for Maaori, particularly taangata whaikaha. This is in breach of the Treaty principles of active protection and equity.

A significant part of our hearing, and of the evidence before us, concerned Cabinet's rejection of an age-adjusted vaccine rollout for Maaori, and their favouring of the whaanau-based approach.

In closing submissions, counsel for Te Ohu Rata o Aotearoa submitted that: "To the extent there was a whaanau-based approach explicitly adopted by the Crown, this was not made clear to Maaori or the general public."⁷³ This sentiment was

67. Transcript 4.1.10, pp 269–270.

68. Ibid, p 243.

69. Document D29, p 4.

70. Document D48, p 33.

71. Ibid.

72. Waitangi Tribunal, *Hauora*, p 138.

73. Submission 3.3.59, p 16.

4.1.6

echoed by counsel for Te Roopuu Taurima O Manukau Trust, submitting that the Crown had indeed ‘failed to take a whaanau centric approach.’⁷⁴ Counsel for the National Hauora Coalition submitted that in their experience, ‘the Crown’s strategies focused on households rather than whaanau.’⁷⁵ Counsel for the New Zealand Maaori Council emphasised in closing submissions that ‘[t]he Crown’s “whaanau-centred” approach was a failure’ and was not the approach that the Crown’s own expert advisers recommended to provide equity for Maaori.⁷⁶

So, why did Cabinet adopt a whaanau-based approach alone, rather than both an age adjustment, *and* a whaanau-based approach? Dr Bloomfield acknowledged that it was ‘quite possible’ that more could have been done to enable a better outcome in the vaccine sequencing plan, and that ‘a heightened sense of action’ was required given the risk posed to Maaori if the vaccine rollout was inequitable.⁷⁷ When questioned on why Cabinet had not heeded the Ministry’s advice to adopt an age-adjuster, Dr Bloomfield replied:

what I know is that Cabinet had a very good discussion on that initial advice of which the age adjustment was one part of how to achieve equity and they came back and said, ‘Actually, we would like to address the equity aspiration and the Treaty obligations in a different way.’⁷⁸

It remains unclear to us whether a significant number of vaccination sites adopted the whaanau-centred approach, or were even conscious of the fact that this was the approach the Government had opted for. It is also not clear to us how older, eligible family members being able to get their younger, ineligible family members vaccinated would have significantly off-set the younger age differential of the Maaori population as a whole.

We also find it odd that Cabinet ended up devising a ‘whaanau-based’ approach to care that was not consistent with hauora Maaori. A whaanau-based approach that was consistent with hauora Maaori would have been available to *all* whaanau, rather than just the whaanau of those who were considered ‘at risk’. If Cabinet wanted to explore a kaupapa Maaori approach to a rollout, there were plenty of proven models they could have chosen from. If they had announced that they would adopt a whaanau ora approach, that would have been a clear message to Maaori about what the programme meant and what it entailed. It would have immediately identified already-existing infrastructure, funding, and a whole range of providers prepared to implement it. Further, they would have been adopting an approach that has proven to be effective for Maaori.

74. Submission 3.3.56, p 9.

75. Submission 3.3.57, p 21.

76. Submission 3.3.50, p 4.

77. Transcript 4.1.10, p 397.

78. *Ibid*, p 412.

The whaanau-based approach appears to have come out of nowhere; there was no explanation of the maatauranga that underpinned it. Unlike the age adjustment recommended by the Ministry and endorsed by public health experts, we have seen no scientific, mathematical, or public health assessment done of the efficacy of the whaanau-based approach.

On the other hand, the age-adjusted approach to the rollout was a proven, thoroughly researched policy option that had equity mathematically built into it and was endorsed by Maaori and the Crown's own public health experts alike. It was also, significantly, given as advice to Cabinet in isolation – based on the Crown's evidence, there were no other policy options for the rollout recommended to Cabinet. That tells us that according to the Crown's own officials, the best mechanism Cabinet could provide for Maaori to ensure the vaccination rollout was equitable was an age-adjusted rollout.

Accordingly, we struggled to understand why Cabinet did not approve the age-adjusted rollout. Professor Shaun Hendy, one of the modellers whose advice the Government relied on throughout the pandemic, said the Government's inadequate prioritisation of Maaori in the rollout, even after Te Puunaha Matatini's advice, remained 'a bit of a mystery'. Professor Hendy concluded that the low vaccination rates of Maaori were 'at least partially a result of the Government's vaccine prioritisation strategy, which was based on age and did not take ethnicity into account'.⁷⁹

Len Cook similarly told us that a primarily age-based vaccination strategy was inherently inequitable to Maaori due to the different age structure of the Maaori population. As he explained, 'from the census itself 30 per cent of the Maaori population is under 15' compared to '16.6 per cent of the non-Maaori population'.⁸⁰ In his evidence, Mr Cook described that:

Using simple statistical analysis, the different demographic structure of Maaori means that when the vaccine rollout strategy favoured older New Zealanders, this has systemically resulted in a gap in coverage for Maaori from non-Maaori. A gap of over 12 percentage of the Maaori population that has been vaccinated emerged by the time the age threshold would have reached 55 years. Figure 2 [redrawn here on page 60] indicates the gaps that can be predicted from a full age-based rollout of the vaccination. The much lower share of the Maaori population than European reflects the highly age structured vaccination thresholds of the rollout initially.⁸¹

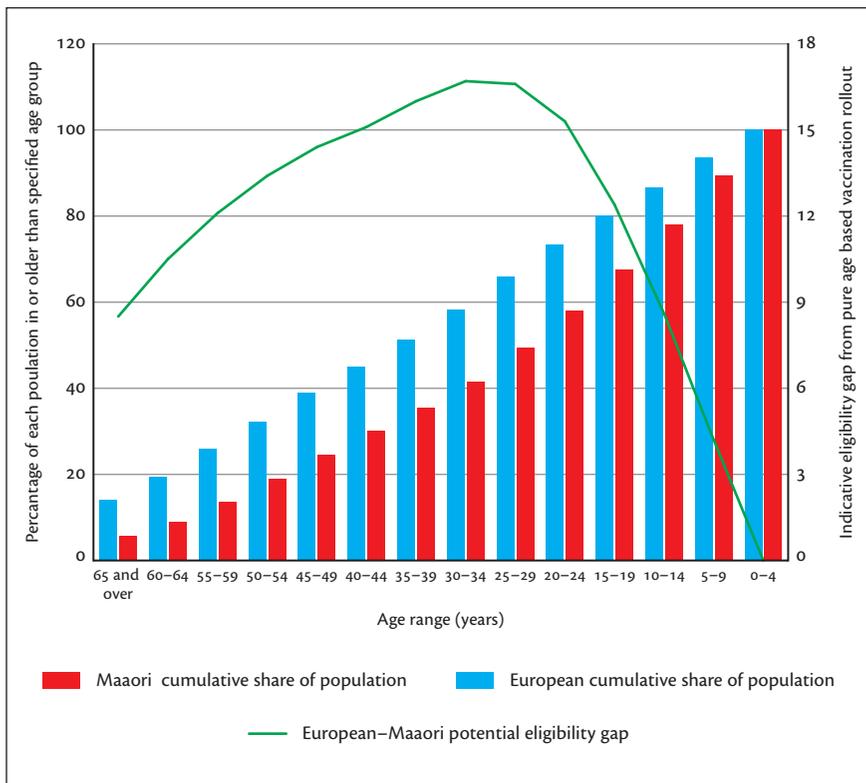
Mr Sporle provided evidence emphasising that, in his opinion, 'the existing vaccination program cannot address the deficit in Maaori vaccination coverage at the required pace to equitably protect Maaori from the largest threat to public health

79. Document D23, p 5.

80. Transcript 4.1.10, p 90.

81. Document D12, p 7.

4.1.6



The indicative effect of Maaori–European population structure effects on the percentage of the population eligible for age-based vaccination rollout.

Redrawn from document D12, figure 2.

in a century.⁸² Mr Sporle also noted the Ministry of Health had acknowledged that the Health Service Utilisation population data undercounts Maaori, resulting in an over-estimation of Maaori vaccination rates.⁸³

When asked, in his expert opinion, what the outcome would have been *had* the age adjustment been adopted, Dr Bloomfield replied:

It's hard to look forward and it's hard to sort of look back at this . . . So, I am not sure I could offer a view on whether the lower age range, at least at the time while we had constrained vaccine supply would have afforded a greater level of protection or a lesser or the same level protection for Maaori communities than has happened.⁸⁴

82. Document D3, p 4.

83. Ibid, p 3.

84. Transcript 4.1.10, p 412.

When asked if there was anything he would have changed if he had made the decision himself, Dr Bloomfield responded:

if a lower age range had been adopted for Maaori and/or Pasifika because that was what was proposed, there is no doubt in my mind that the only thing that would have worked to ensure that that was of benefit was that whaanau-based approaches had been adopted. We saw the benefit of enabling those for those early high vaccination rates in over 65s. And so the key question would have been, what else would have needed to have been or could have been done – I mean a key question could have been regardless of where the decision landed on the age range. And so, again, that probably would have required further vaccine to be allocated out to those providers and also further funding to enable them to reach a wider age range. So I guess our advice would have been, if that [age-adjusted rollout] had been adopted by Cabinet . . . then we would have provided advice around what would be needed to enable that approach.⁸⁵

When cross-examined by claimant counsel on Cabinet's decision not to adopt an age adjustment, but rather a whaanau-based approach, Dr Bloomfield told us that the 'decision was taken with a very strong understanding of both the inequities' and of the 'requirement that specific initiatives be implemented to address those inequities'.⁸⁶

Ms Gibbs told us, that 'I think an age range – again with the benefit of hindsight – would have been of course very easy to define. We would have been able to count that specific population and know what we were targeting'.⁸⁷

It is clear that the lag in Maaori vaccination has been in large part caused by the failure to adopt an age-adjusted approach, support an effective whaanau-based approach, and to adequately fund Maaori providers early enough to implement effective models for their communities. This meant that the burden of adverse health outcomes has fallen far more severely upon Maaori.

We do not consider the Crown had sufficient justification to ignore the age-adjusted approach, in the context of its heightened obligation to actively protect Maaori health in a pandemic. Moreover, Cabinet's hesitancy to take up Maaori advice and research is contrary to the wide acceptance that Maaori approaches are required to achieve equity for Maaori.

While we are sceptical of the whaanau-based approach based on the evidence received, we cannot comprehend why, either from a public health or Treaty perspective, the whaanau-based approach could not have been *in addition to*, rather than instead of, an appropriate age adjustment for Maaori and other population groups. While the degree to which it might have made a difference is unclear, the expert evidence before us from both the Crown and the claimants indicates that the combination of these two approaches would have made a difference.

85. Ibid, p 413.

86. Ibid, p 427.

87. Ibid, p 413.

4.1.6

Dr Bloomfield's and Ms Gibbs' answers to questions from us, and from counsel, was to emphasise the different roles of Cabinet and public servants.⁸⁸ Those officials were then tasked with rolling out the alternative approach that Cabinet approved as equitably as they could in the circumstances. Even Crown counsel, in closing arguments, could not explain Cabinet's motivation for rejecting an age adjustment for Maaori.⁸⁹

In answers to written questions, Minister Chris Hipkins said that the reason Cabinet rejected the February 2021 advice was:

At that time, the country was confronted with limited vaccine supply. The best way to protect all New Zealanders, including Maaori, and in particular the most vulnerable New Zealanders, which disproportionately include Maaori, was to attempt to keep the virus out of the country. The border and health workers were therefore prioritised, alongside the most vulnerable population being those aged 65 and over. At that time, and given the vaccine scarcity, diverting more of the limited available vaccine supply towards younger Maaori would have entailed diverting it away from other more vulnerable groups, or those groups who would be more likely, if vaccinated, to impede the entry of the virus into the country through the border.⁹⁰

First, we agree that the prioritisation of border workers and health workers, and indeed the general logic behind the prioritisation of Group 1 and Group 2, overall makes sense from a Treaty perspective. While there was some question as to whether the Crown's changes to some measures in Group 2 adequately captured Maaori given there was no age adjustment in Group 3, the rationale for prioritisation in Group 1 was not an issue in contention between the Crown and the claimants and interested parties.

However, the Minister's assertion that 'the most vulnerable population being those aged 65 and over' ignores that the age adjustment was to address the fact that, due to co-morbidities and the social determinants of health, younger Maaori are about as vulnerable as older Paakehaa. Again, Professor Hendy, summarising advice he gave the Crown that informed the age adjustment recommendation, said that, even accounting for co-morbidities and the social determinants of health, 'a 59-year-old Maaori patient with COVID-19 and no co-morbidities had the same risk of hospitalisation as an 80-year-old Paakehaa without co-morbidities.'⁹¹

Secondly, there is no evidence on our record, including from the Crown's own officials, to corroborate Minister Hipkins' assertion that adopting an age-adjusted rollout for Group 3 would 'divert' the vaccine from other vulnerable groups – rather, the point of Crown officials' recommendation was to make sure it was equitably accessed by Maaori due to their younger age profile.

Finally, we note that Cabinet's concerns with supply in February 2021 were no

88. Transcript 4.1.10, p 428.

89. Ibid, pp 621–622.

90. Document D51(a), pp 1–2.

91. Document D23, p 4.

longer an issue by the time the Group 4 rollout began at the end of July 2021.⁹² While it seems clear the most equitable approach would have been for Cabinet to have approved the Group 3 age adjustment in February as was recommended, we do not see why Cabinet could not have still approved the age adjustment to start Maaori eligibility for Group 4 immediately at 50 years and over once supply was no longer an issue.

Based on the evidence we heard, it is clear that an age adjustment would have made a measurable, equitable difference to Maaori vaccination rates. If Maaori had been prioritised through an age adjustment earlier as per public health advice, the inequity in the rollout would have been greatly reduced.

The Treaty principle of active protection and public health principles about how to achieve equitable outcomes dictate that the key mechanism available to Cabinet to get the best outcome possible for Maaori was to expressly prioritise Maaori in the vaccine rollout. The option recommended to Cabinet for an age adjustment for Maaori was consistent with these principles, was achievable, and was the superior option to the one Cabinet adopted. Therefore, Cabinet did not actively protect Maaori to the fullest extent practicable.

We find that Cabinet's decision to reject advice from its own officials to adopt an age adjustment for Maaori in the age-based vaccine rollout breached the Treaty principles of active protection and equity.

On 19 September 2021, seven months after the vaccine rollout began and a month into what would become the most serious COVID-19 outbreak since the start of the pandemic, only one-quarter of eligible Maaori were fully vaccinated.⁹³ On the same date, 38 per cent of the eligible general population were fully vaccinated.⁹⁴ At the time, the Government declared the modest progress in Maaori vaccination rates to that point as proof that the whaanau-based approach was working.⁹⁵

4.2 THE COVID-19 PROTECTION FRAMEWORK

4.2.1 The need for a new strategy to manage the Delta variant

The evidence we received in this inquiry is clear that the infection rate of the Delta variant rendered the 'elimination' strategy Aotearoa New Zealand had pursued since the beginning of the pandemic, supported by long-term lockdowns, untenable.

92. Honourable Chris Hipkins, 'Early Pfizer Shipment Boosts Vaccine Schedule', media release, 19 July 2021, <https://www.beehive.govt.nz/release/early-pfizer-shipment-boosts-vaccine-schedule>.

93. Honourable Peeni Henare, 'Major Milestones for Maaori COVID-19 Vaccine Rollout as New Campaign Launches', media release, 19 September 2021, <https://www.beehive.govt.nz/release/major-milestones-m%C4%81ori-covid-19-vaccine-rollout-new-campaign-launches>; Ministry of Health, '24 Community Cases of COVID-19; More than 50,000 Vaccines Administered Yesterday', media release, 19 September 2021, <https://www.health.govt.nz/news-media/media-releases/24-community-cases-covid-19-more-50000-vaccines-administered-yesterday>.

94. Ministry of Health, '24 Community Cases of Covid-19'.

95. Henare, 'Major Milestones for Maaori'.

4.2.1.1

As a result, in September and early October 2021, the Government decided to move to a ‘minimise and protect’ strategy and formulated the COVID-19 Protection Framework. This strategy and framework would tolerate COVID-19 cases in the community but was predicated on ‘a highly vaccinated New Zealand.’⁹⁶ The National Iwi Chairs Forum Pandemic Response Group agreed with the intent of a new strategy, as long as Maaori were highly vaccinated.⁹⁷

We heard evidence that the need for a new strategy was precipitated by the significant economic impacts of ongoing lockdowns and waning social licence for the restrictions of the Alert Level system.

4.2.1.1 *Economic impact of prolonged lockdowns*

We heard evidence from Te Puni Kookiri that lockdowns had had ‘significantly disproportionately negative impact[s] on Maaori.’⁹⁸ For instance, on 10 November, Te Puni Kookiri informed the DPMC these impacts were not just economic but spanned into Maaori education and employment.⁹⁹ Likewise, Cabinet papers on Alert Level change decisions from August to October 2021 all emphasise the economic impacts of lockdowns on Maaori and non-Maaori businesses.¹⁰⁰ Ms Fairhall

96. Document D50, p 9.

97. Ibid, pp 17–18.

98. Document D45, p 12.

99. Ibid.

100. Honourable Chris Hipkins, ‘COVID-19 Response: Further Auckland Community Cases: Review of Alert Level’, Cabinet paper, 20 August 2021, <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/26-Nov-2021/ALC2-20802021-COVID-19-Response-Further-Auckland-Community-Cases.pdf>; Honourable Chris Hipkins, ‘COVID-19 Response: 23 August Review of Alert Level Settings’, Cabinet paper, 23 August 2021, <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/26-Nov-2021/ALC3-23082021-COVID-19-Response-23-August-Review-of-Alert-Level-Settings.pdf>; Honourable Chris Hipkins, ‘COVID-19 Response: 27 August 2021 Review of Alert Settings’, Cabinet paper, 27 August 2021, <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/26-November-2021/ALC4-27082021-COVID-19-Response-27-August-Review-of-Alert-Level-Settings.pdf>; Honourable Chris Hipkins, ‘COVID-19 Response: 30 August 2021 Review of Alert Settings’, Cabinet paper, 30 August 2021, <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/26-November-2021/ALC5-30082021-COVID-19-Response-30-August-Review-of-Alert-Level-Settings.pdf>; Honourable Chris Hipkins, ‘COVID-19 Response: 6 September 2021 Review of Alert Settings’, Cabinet paper, 6 September 2021, <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/26-November-2021/ALC6-06092021-COVID-19-Response-6-September-Review-of-Alert-Level-Settings.pdf>; Honourable Chris Hipkins, ‘COVID-19 Response: 13 September 2021 Review of Alert Settings’, Cabinet paper, 13 September 2021, <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/26-November-2021/ALC7-13092021-COVID-19-Response-13-September-Review-of-Alert-Level-Settings.pdf>; Honourable Chris Hipkins, ‘COVID-19 Response: 20 September 2021 Review of Alert Settings’, Cabinet paper, 20 September 2021, <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/26-November-2021/ALC8-20092021-COVID-19-Response-20-September-Review-of-Alert-Level-Settings.pdf>; Honourable Chris Hipkins, ‘COVID-19 Response: 4 October 2021 Review of Alert Settings’, Cabinet paper, 4 October 2021, <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/26-November-2021/ALC9-04102021-COVID-19-Response-4-October-Review-of-Alert-Level-Settings.pdf>; Honourable Chris Hipkins, ‘COVID-19 Response: 11 October 2021 Review of Alert Settings’, Cabinet paper, 11 October 2021, <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/26-November-2021/ALC10-11102021-COVID-19-Response-11-October-Review-of-Alert-Level-Settings.pdf>; Honourable Chris Hipkins,

stated that the estimated economic impact of the three-month Auckland lockdown from August 2021 was roughly \$10 billion, or 10 per cent of gross domestic product. We accept her assessment that this is ‘not insignificant’.¹⁰¹

4.2.1.2 Waning social licence for prolonged lockdown

Secondly, we accept the general thrust of the argument that waning social licence warranted a new strategy. Dr Bloomfield and Ms Fairhall both gave evidence that ‘social licence for protracted lockdowns under the alert level system was waning’, in that non-compliance with Alert Level restrictions was increasing.¹⁰²

Ms Fairhall’s brief explained that DPMC assessed social licence based on statistical information provided by New Zealand Police, including:

- ▶ the number of breach notifications Police receive and infringement notices they issue;
- ▶ involvement in COVID-19-related activities like Health Act breaches, call outs to mass gatherings, and checks; and
- ▶ statistics from essential facilities and vehicle checkpoints.

They also assess ‘[m]ore detailed information’ from Police about ‘protest activity, media reporting about breaches, requests for business travel documentation, misinformation, and general public sentiment’; and ‘[i]nformation collected by the communications team in DPMC from monitoring social media and conducting polls’.¹⁰³

Ms Fairhall also said that ‘anecdotal evidence’ as part of ‘daily conversations’ between Ministers, officials, and public health units in Auckland also informs the Crown’s understanding of social licence.¹⁰⁴ We did not get a clear explanation of the extent to which ‘anecdotal evidence’ informed decision-making. However, we acknowledge Ms Fairhall’s evidence reveals that, in general, the Government was concerned that social licence for prolonged lockdowns was diminishing, or might diminish imminently.

As Minister Hipkins stated: ‘Our control of COVID-19 through public health measures relies on public buy-in.’¹⁰⁵ Likewise, Ms Fairhall stated, ‘there may not be much point in having [public health measures]’ if people stop following them.¹⁰⁶

Minister Hipkins also stated:

the Delta outbreak had spread to communities in the upper North Island who were not complying or were not able to comply with lockdown restrictions. This includes communities involved in criminal activity who had no regard for the restrictions.

‘COVID-19 Response: 18 October 2021 Review of Alert Settings’, Cabinet paper, 18 October 2021, <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/26-November-2021/ALC11-18102021-COVID-19-Response-18-October-Review-of-Alert-Level-Settings.pdf>.

101. Transcript 4.1.10, p 462.

102. Ibid, p 384; doc d50, p 27.

103. Document D50, p 9.

104. Transcript 4.1.10, p 463.

105. Document D51, p 4.

106. Transcript 4.1.10, p 462.

4.2.2

The notion of lockdowns being honoured in the breach, so to speak, among certain communities, also raised doubts about the justification for imposing and maintaining restrictions on those members of the community who were complying.¹⁰⁷

Consent of the population is important. Non-compliance with public health measures puts Maaori, as well as the rest of the country, at risk. We note, however, that ‘willingness to comply’ is not the only factor determining people’s adherence to restrictions. Compliance also depends on people’s practical ability to comply with the rules, which is part of the Government’s kaawanatanga role to enable. Ms Fairhall said she was aware of concerns from Maaori leaders that some people could not comply with lockdown rules due to, in part, overcrowded housing.¹⁰⁸

In written responses to questions from claimant counsel, Minister Hipkins also confirmed that no advice was requested or policy work done that specifically looked into the issue of communities that were unable to follow restrictions or had fewer resources to follow restrictions.¹⁰⁹

It is unfair, in our view, to effectively make communities responsible for not complying with the rules, if the other social determinants of health are not actively supported by Government measures. Focusing on ‘social compliance’ presupposes that the approach was designed for nuclear families that do not have to contend with overcrowded housing or poor social outcomes, not for the communities who were most at risk – including Maaori.

4.2.2 Cabinet plans a new approach based on a ‘highly vaccinated’ population

On the basis that the central premise of the ‘minimise and protect’ strategy was high vaccination rates, early consultation with Maaori indicated general acceptance of a different framework to manage the Delta variant. However, Maaori emphasised that achieving high vaccination rates would mean a need to focus on Maaori communities.

When the COVID-19 Protection Framework was first formally proposed to Cabinet on 27 September, in a paper entitled ‘COVID-19: A Strategy for a Highly Vaccinated New Zealand’, officials envisioned the change in framework once case numbers in Auckland were back to zero and vaccination rates were sufficiently high.¹¹⁰

By 4 October, DPMC advised that the transition to the Protection Framework would ‘need to occur while COVID-19 cases continued to emerge and while vaccination rates continued to build.’¹¹¹

Cabinet papers on both dates noted the transition to the new framework could ‘exacerbate existing inequities’ amongst population groups with low vaccination rates (Maaori and Pasifika), and that ‘early consultation with our Treaty

107. Document D51, pp 4–5.

108. Transcript 4.1.10, p 482.

109. Document D51(a), p 12.

110. Document D50(a), p 34.

111. Document D50, pp 12–13.

partners' and improving the vaccine rollout for Maaori would be important.¹¹² The 4 October paper recorded feedback from the National Iwi Chairs Forum on the need to prevent disproportionate impacts on Maaori of transitioning to the Protection Framework, which noted that 'vaccinations were the key to this.'¹¹³

Overall, we consider that in its initial conception as reliant on high vaccination rates, and given the threat of Delta, the Government did not breach the Treaty when it decided it needed to shift to the Protection Framework.

4.2.3 Cabinet consults on the Protection Framework (early to mid-October)

Throughout October, DPMC consulted widely about the draft Protection Framework. These groups were:

- ▶ the Strategic COVID-19 Public Health Advisory Group (8 October);
- ▶ National Iwi Chairs' Forum Pandemic Response Group (8 October);
- ▶ the Ministry of Health (10 October);
- ▶ modellers from Te Puunaha Matatini (10 October);
- ▶ expert advisory group convened by Sir David Skegg (12 October);
- ▶ non-Cabinet Ministers (14 October);
- ▶ a special meeting of public health experts (15 October);¹¹⁴
- ▶ Te Arawhiti (15 October);
- ▶ Te Puni Kookiri (16 October); and
- ▶ hui with around 50 Maaori iwi and health leaders (15 to 17 October).

4.2.3.1 Coming up with a vaccination threshold

Through this consultation the Government was reminded, many times, of its obligation to ensure equitable health outcomes for Maaori. All of these groups gave feedback that the Protection Framework would put Maaori at disproportionate risk so long as their vaccination rate remained lower than the general population, and stressed that vaccine uptake needed to increase across all population groups, especially Maaori and Pasifika, before any shift to the new system.

As an example, on 8 October, the Strategic COVID-19 Public Health Advisory Group stated that 'it was inevitable that the new approach proposed would widen the gap in health equity that already exists,' particularly for Maaori and Pasifika, and that vaccination rates would need to increase in response.¹¹⁵ On the same day, the National Iwi Chairs Forum recommended among other things: '[a]n equity assessment of all proposed levels and measures in the framework be completed ahead of implementation.'¹¹⁶

112. Document D50(a), pp 46–47, 69–70.

113. Document D50, p 13.

114. These experts were Ian Town, Juliet Gerrard, David Skegg, Ramon Pink, Sally Roberts, Nigel French, Rod Jackson, David Murdoch, Nick Eichler, Matire Harwood, Nigel Raymond, Andrew Old, Michael Baker, Maria Poynter, Susan Jack, Erasmus Smit, Shaun Hendy, Rawiri Jansen, Jin Russell, Samantha Murton, Patricia Priest, Felicity Dumble, Bryan Betty, Siouxsie Wiles, Colin Tukuitonga, Anja Werno, Virginia Hope, Dianne Sika-Paotonu, and Caroline McElnay (doc D50, p 19).

115. Document D50, p 16.

116. *Ibid*, p 17.

On 14 October, Cabinet and non-Cabinet Ministers met to discuss how the country should transition to the Protection Framework. Ms Fairhall noted that ‘concerns about the increased vulnerability of Maaori to COVID-19 and their lower vaccination rates were also discussed at the meeting.’¹¹⁷

Again, on 15 October, the Government convened a meeting with public health experts to review a draft version of the Protection Framework.¹¹⁸ These experts stated that a ‘strong equity response’ was required. In their view, the overall success of the strategy was its ability to protect Maaori and Pacific populations. Ms Fairhall’s brief of evidence also notes that Maaori experts at this hui ‘were concerned about the lack of co-design’ in the Protection Framework and stated that the framework ‘should be Te Tiriti-based, with an explicit goal to save Maaori lives’, and ‘must include Maaori and Pacific leadership.’¹¹⁹

Te Arawhiti also gave feedback on 15 October, on a Cabinet paper entitled ‘Reconnecting New Zealanders’. The agency recommended strengthening the paper by explicitly noting the higher risks on Maaori of opening up, including Maaori-outcome-specific modelling, and giving risk assessments an explicit Maaori lens. The agency further advised that it was concerned ‘the paper did not adequately acknowledge the differential impact on Maaori from the opening up activities proposed’. The agency also advised that ‘further detail was required on the extent and nature of Maaori engagement and whether Maaori would have input into decisions about the prioritisation or border setting changes.’¹²⁰

Over 15 to 17 October, the same weekend as the Super Saturday vaccination drive (16 October), Maaori Ministers held three Zoom hui with around 50 iwi leaders, Maaori health experts, Whaanau Ora practitioners, and Maaori health experts, to discuss the draft Protection Framework. The leaders were now unequivocal in their rejection of the framework. They discussed the need for a vaccination threshold and clearly were considering these targets in light of census and Health Service User undercounting of Maaori, with some discussion of a target as high as 95 per cent or 100 per cent for the Maaori population group.¹²¹ They reflected similar concerns to all the aforementioned groups consulted during October.

The evidence provided to us about this early to mid-October period indicates Ministers were made aware of the possible risks of the Protection Framework for Maaori, of their obligation to implement an equitable response, and had received proposals from a range of groups of what an equitable response would look like. Crown counsel acknowledged that ‘the Crown has not been ignorant of the extent of need or the facts about inequity.’¹²²

Many of the aforementioned groups gave specific feedback on the circumstances in which a new framework, based on recognition that COVID-19 transmission was

117. Document D50, p 22.

118. Ibid, p 19.

119. Ibid, p 20.

120. Document D46, p 8.

121. Document D46(a), p 70.

122. Submission 3.3.58, p 3.

Proposed by	Target	Date proposed
National Iwi Chairs Forum Pandemic Response Group	95 per cent of eligible Maaori*	4 October 2021
Ministry of Health	90 per cent of the adult population, 5–11-year-olds, and among vulnerable groups (including Maaori and Pasifika)†	4 October 2021
Public health and Maaori experts‡	Same as Ministry of Health advice§	15 October 2021
Maaori leaders consulted over Super Saturday weekend	At least 90 per cent of eligible Maaori, though they opposed the COVID-19 Protection Framework overall	15–17 October 2021
Te Puni Kookiri	90 per cent of the eligible population within all ethnic groups	16 October 2021

* Document D50, p 17.

† Ibid, p 14.

‡ These experts were Ian Town, Juliet Gerrard, David Skegg, Ramon Pink, Sally Roberts, Nigel French, Rod Jackson, David Murdoch, Nick Eichler, Matire Harwood, Nigel Raymond, Andrew Old, Michael Baker, Maria Poynter, Susan Jack, Erasmus Smit, Shaun Hendy, Rawiri Jansen, Jin Russell, Samantha Murton, Patricia Priest, Felicity Dumble, Bryan Betty, Siouxsie Wiles, Colin Tukuitonga, Anja Werno, Virginia Hope, Dianne Sika-Paotonu, and Caroline McElna (doc d50, p 19).

§ Document D50, pp 19–20.

Vaccination thresholds at which the country should move to the Protection Framework, proposed to the Government throughout October 2021.

inevitable and that elimination was no longer viable, should be implemented. The table below indicates most of the groups consulted throughout October preferred, at minimum, that 90 per cent of the eligible Maaori population was vaccinated before a move to the Protection Framework. Rather than this target being a guaranteed point at which Maaori would be protected, experts saw these targets as part of an equitable move to the new framework.

4.2.3.2 Strengthening the ‘Red’ and ‘Green’ settings in the Protection Framework

During the October consultation period, several of the groups also expressed that the proposed settings for the ‘Red’ level of the proposed framework were not strong enough, including the Strategic COVID-19 Public Health Advisory Group,¹²³ and the National Iwi Chairs Forum.¹²⁴ The experts consulted on 15 October also recorded that: ‘The restrictions in the framework did not appear strong enough in any of the levels to control COVID-19.’¹²⁵

Ms Fairhall explained that the ‘Red’ and ‘Green’ settings in the framework were strengthened in response to this consultation ahead of the 22 October

123. Document D50, p 15.

124. Ibid, p 17.

125. Ibid, p 21.

announcement of the framework. She stated that ‘for unvaccinated [people] there’s more restrictions at green than there were in the original draft.’¹²⁶ In addition, she said localised lockdowns were introduced to further strengthen the framework.¹²⁷

4.2.4 Cabinet decides to move to the Protection Framework when each district health board catchment achieves 90 per cent full vaccination (mid-October)

On 18 October, Cabinet met to consider a further developed draft of the Protection Framework. At this point, 66 per cent of the general population had received two vaccination doses, compared with 45 per cent of the Maaori population.¹²⁸

Ms Fairhall told us that the original recommendation considered by the DPMC for the 18 October Cabinet paper was for a vaccination threshold of 90 per cent of people over the age of ‘40 or 50’ in each district health board.¹²⁹ She acknowledged that this threshold was not in advice from the Ministry of Health on our record of inquiry, but said that ‘there had been discussions during the week’ leading up to 18 October. Although the final recommendation in the 18 October paper was for a 90 per cent threshold of all the eligible population in each district health board, she said this was a ‘late change’.¹³⁰

Lil Anderson provided us a copy of some talking points for Minister Kelvin Davis prepared for the 18 October Cabinet meeting.¹³¹ These talking points communicated, in no uncertain terms, the views of those Maaori who had met with him and other Ministers over the weekend. According to the talking points, the Maaori Ministers recommended that Cabinet:

note that Maaori leadership *rejected* the COVID-19 Protection Framework but are aware that it is likely to proceed;

agree that a target for vaccination rates of at least 90%, to be measured and reported at the DHB level with a focus on driving up the vaccination rate of Maaori between the age of 20–34;

agree in principle today to a new fund administered by Te Arawhiti, Te Puni Kookiri and MoH collectively and released through their established channels to iwi, whaanau ora providers and community organisations with a paper to follow to the Minister of Finance;

note that Maaori leadership are united in their desire to continue engaging and are seeking opportunities for co-design and partnership throughout the implementation of the new framework;

126. Transcript 4.1.10, p 464.

127. Ibid.

128. Ministry of Health, ‘60 Community Cases of COVID-19; 5 New Border Cases; 89 Percent of Aucklanders Complete One Vaccine Dose’, media release, 18 October 2021, <https://www.health.govt.nz/news-media/media-releases/60-community-cases-covid-19-5-new-border-cases-89-percent-aucklanders-complete-one-vaccine-dose>.

129. Transcript 4.1.10, pp 474–475.

130. Ibid, p 474.

131. Document D46, p 5.

agree that a group representing a range of Maaori work with key agencies on any detailed planning or transition planning to the new framework;

note that Maaori leadership are of the view that for any roll out of the framework to successfully reach Maaori communities, messaging about the framework to Maaori communities must be led by Maaori;

agree that we work to develop a Maaori communications plan alongside general public communications about the new framework.¹³²

The subsequent Cabinet minute adjusted the recommendations originally set out in the Cabinet paper. Cabinet agreed to a 90 per cent vaccination threshold per district health board. Cabinet also authorised several Ministers to ‘take decisions on providing additional funding to improve the rate of vaccination of Maaori’.¹³³

In a 19 October Cabinet briefing from DPMC, officials suggested that simultaneous operation of the frameworks would pose difficulties for Police; for clear communication; exacerbate already ‘waning social licence’; and pose issues for stopping the spread of COVID-19 throughout the country as, ‘when Auckland transitions to “Red” in the New Framework, Aucklanders would be able to travel around the country’, meaning COVID-19 may spread around the country regardless of what framework the rest of the country was in.¹³⁴ This briefing proposed, for the first time, the possibility of moving the rest of the country to the COVID-19 Protection Framework when Auckland district health boards hit the 90 per cent vaccination rate.¹³⁵

Regardless, on 22 October, Prime Minister Jacinda Ardern publicly announced that Auckland would adopt the Protection Framework when it reached a 90 per cent vaccination rate across all three of its district health boards, and that the rest of the country would move when 90 per cent was reached in the remaining district health boards. In her announcement, she explained the reason for the 90 per cent per district health board vaccination threshold for triggering the shift to the Protection Framework:

A target of 90 percent fully vaccinated across each DHB region has been set as the milestone to trigger moving the country into the new system. This target ensures good regional spread across the country and will also help address equity issues within each region.

Modelling shows having 90 percent of eligible people fully vaccinated provides a high level of coverage, keeping most New Zealanders safe and helping slow and control outbreaks, assisting public health authorities to do their job.¹³⁶

132. Document D46(a), pp 70–73.

133. Document D50(a), pp 149–150.

134. Document D50, pp 26–28.

135. *Ibid*, pp 27–28.

136. Right Honourable Jacinda Ardern, ‘New COVID-19 Protection Framework Delivers Greater Freedoms for Vaccinated New Zealanders’, media release, 22 October 2021, <https://www.beehive.govt.nz/release/new-covid-19-protection-framework-delivers-greater-freedoms-vaccinated-new-zealanders>.

4.2.5 The Government announces the Maaori Communities COVID-19 Fund (mid-October)

Also on 22 October, the Government announced a \$120 million contestable fund to assist with the transition, called the Maaori Communities COVID-19 Fund. It comprises:

- ▶ \$60 million for the mobilisation of communities to connect whaanau to the vaccine and to accelerate vaccine uptake, with a focus on removing barriers to vaccination, and reaching ‘hard-to-reach’ areas; and
- ▶ \$60 million for increasing community resilience, ensuring access to information and resources, and supporting locally led and co-designed approaches to managing and minimising the impacts of COVID-19.¹³⁷

In her oral evidence, Crown witness Grace Smit said:

On the 22nd of October funding was announced by Ministers. If we took this as day 0 it was on day 4, the fourth working day following this, that the first tranche proposals were provided to Ministers. This tranche of proposals was for \$24 million. It was on day 5, a day later, that we received those approvals back from Ministers and it was on day 6 that the first contracts were issued and then on day 7 that the money went out. I acknowledge that that wouldn't have been the experience of every provider but I'm happy to give the Tribunal a more detailed breakdown of the timeframes of each contract we have in place.

While acknowledging the importance of timely responses, I'd like to pause and acknowledge that in the two months since, Maaori health providers have vaccinated over 152,000 Maaori, a 54.7 per cent increase and twice the national increase of 27.1%. Our communities in the face of frustration and sometimes limited resources and much pressure, have still at speed delivered to our many people protecting both whaanau and whakapapa.¹³⁸

However, as counsel for the New Zealand Maaori Council stated in closing submissions, although ‘22 October 2021 might have been day zero with respect to the announcement of the new fund . . . it was day 602 of the New Zealand pandemic.’¹³⁹ As he stated in our hearing, even if the Crown was ‘scrambling’ to address the concerns of Maaori ‘in good faith . . . that doesn't mean there wasn't a [Treaty] breach because there was 602 days before that when not enough was done.’¹⁴⁰

Lee Colquhoun and Shelley Cunningham of Te Puna Ora o Mataatua Trust explained that support from the fund had only just started to reach Te Puna Ora in the week commencing 15 November 2021, despite being announced on 22 October.¹⁴¹ They argued:

137. Document D45, pp 10–11.

138. Transcript 4.1.10, p 504.

139. Submission 3.3.50, p 10.

140. Transcript 4.1.10, p 523.

141. Document D43, para 92.

In real terms, the November 2021 funding will not crystallise into an operational resource until the new year. . . . [it] will not give us the ability to surge in time for the opening of the Auckland border on 15 December 2021. It will also not give us the ability to surge in time for the second dose of the vaccination mandate on 1 January 2021.¹⁴²

They stated that the funding was having a positive impact on Maaori vaccination in their rohe (Eastern Bay of Plenty), but that they need more time to 'do our job' without the Crown 'chang[ing] the goal post' and opening the Auckland border.¹⁴³

Andrew Sporle argued the fund provided 'far too little, far too late' due to the pre-existing disparities caused by the failure to adjust the vaccination sequencing by age. He argued that the fund's resources 'were actually required' earlier, to 'get the vaccination roll out happening as quickly and as sufficiently as possible'. He also stated that this funding failed to acknowledge that Maaori are 'currently trying to manage vaccination roll out and an active outbreak'.¹⁴⁴

Eleanor Hamlin-Paenga, chief executive officer of Ngaati Kahungunu ki Pooneke Community Services (KWS), stated that 'District Health Boards have been given the gate-keeping position for funding for vaccination and the broader COVID-19 response', which is not solved by the Maaori Communities COVID-19 Fund as it 'augment[s] and supplement[s] the earlier DHB funding'. As such, it will rely 'on the equity with which the initial funding was released'.¹⁴⁵ She said that '[i]n planning this service, we need the DHB's to get out of our way. They do not understand the communities who are now the central priority of the country's COVID-19 response'.¹⁴⁶

Due to the slow speed of funding actually reaching organisations, Rowena Ngaio Tana, chairperson of the Ngaati Hine Health Trust, said they had to pay invoices out of their own funds. Funding goes to district health boards and is then split off to various Maaori providers. She said it feels like the district health board allocates money to the 'easy option rather than the right one'.¹⁴⁷ In Ms Tana's view, the district health board 'just relied on Maaori Health Providers to serve the people of the Mid-North on our limited budget and limited resources'.¹⁴⁸ She also said the Crown needs to address the 'fragmentation of funding distribution and inconsistency in policy administration which leaves us in a position of confusion'.¹⁴⁹

142. Ibid, para 95.

143. Ibid, para 112.

144. Transcript 4.1.10, p 333.

145. Document D27, pp 4-5.

146. Ibid, p 9.

147. Document D17, p 7.

148. Ibid, p 8.

149. Ibid, p 10.

4.2.6 Cabinet rescinds its district health board vaccination threshold goals (mid-November)

In early November, DPMC began considering advising Cabinet to implement the Protection Framework from 29 November. At this point the 90 per cent threshold for district health boards was still in place, but Te Arawhiti raised serious concerns about this, stating that a shift on 29 November was not sufficient time for Maaori groups to prepare.¹⁵⁰

On 11 November, Te Arawhiti wrote to Minister Kelvin Davis, advising him of the feedback the agency provided on several Cabinet papers in the preceding weeks relevant to the Maaori position in the COVID-19 pandemic. Te Arawhiti noted that the proposals it had viewed did not appropriately take the disproportionate impacts on Maaori into consideration. They were not satisfied with the Crown's consultation of Maaori, stating it was not enough to inform proposals this significant in nature. Further, they stated that 'lack of detail about the design and implementation of the locally led wellbeing support system does not provide us with confidence that this will sufficiently protect Maaori'; and that 'in any case, a 29 November shift to the Protection Framework does not provide Maaori groups enough time to plan or put in place protection to prevent significant impacts on Maaori from the expected increased prevalence of COVID-19 around the country'. Te Arawhiti recommended a delay in opening the Auckland border.¹⁵¹

Likewise, on 14 November, Te Arawhiti stated: 'there has been no engagement on a change to the 90% DHB trigger for transition to framework and removal of Auckland boundary . . . or the consequences of having very little time to prepare for likelihood of more widespread Covid in the community.'¹⁵²

On 15 November, Cabinet confirmed that, subject to public health advice, it would move Auckland into the 'Red' setting in the week beginning 29 November, and move the rest of the country to the Protection Framework at the same time. Restrictions to the Auckland border would lift on 15 December, at which point it was projected the Auckland district health boards would have reached 90 per cent vaccination rates.¹⁵³

The Prime Minister publicly announced the Government had rescinded the 90 per cent per district health board vaccination threshold on 17 November, and signalled that areas with low vaccination rates would also move into the 'Red' setting alongside Auckland.¹⁵⁴ At this point, 82 per cent of the eligible total

150. Document D46, pp 8–9.

151. Ibid.

152. Ibid, pp 9–10.

153. Right Honourable Jacinda Ardern and Honourable Chris Hipkins, 'COVID-19: Transition to the COVID-19 Protection Framework and the Auckland Alert Level Boundary', Cabinet paper, 15 November 2021, <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/10-Dec-2021/Vaccine-Certificates-and-CPF/COVID-19-Transition-to-the-COVID-19-Protection-Framework-and-the-Auckland-Alert-Level-Boundary.pdf>.

154. Right Honourable Jacinda Ardern, 'Next Steps in our COVID-19 Response', media release, 17 November 2021, <https://www.beehive.govt.nz/speech/next-steps-our-covid-19-response>.

population were fully vaccinated compared with 62 per cent of the eligible Maaori population.¹⁵⁵

In the 22 November Cabinet minute, Cabinet confirmed the decision to move the whole country to the Protection Framework and rescinded its previous decision that the transition would occur when a 90 per cent vaccination rate was reached by each district health board. Again, it is notable that this district health board vaccination threshold was proposed by Maaori leaders as an absolute minimum standard, in the context of a framework that they rejected overall.¹⁵⁶

No clear explanation was presented to us about why Cabinet made this sudden move. We received evidence that Cabinet was considering the potential ‘legal and operational challenges’ of operating the Alert Level and COVID-19 Protection Frameworks simultaneously on 18 October 2021.¹⁵⁷ However, at this time, these challenges were given as reasoning by DPMC to Cabinet for accepting a 90 per cent target for a move to the framework.¹⁵⁸ As noted in the preceding section, DPMC’s briefing to Cabinet the day after its 18 October Cabinet meeting reveals some apprehension on DPMC’s part to operating two systems at once, but the Government ultimately announced the vaccination threshold as the trigger three days later.

4.2.7 Cabinet decides future traffic light settings for country (late November)

On 26 November, Te Arawhiti provided advice to the DPMC about a Cabinet paper seeking decisions on COVID-19 Protection Framework settings for each region, and proposed Whanganui, Taranaki, the Bay of Plenty, Tairāwhiti, Lakes, and Waikato to begin in ‘Red’ on the basis of, among other things, low Maaori vaccination rates, and expected high numbers of visitors from Auckland over summer.¹⁵⁹

This was taken into account in Cabinet’s decision on 29 November to transition Taupoo, Rotorua Lakes, Gisborne, Oopootiki, Wairoa, Kawerau, Whakataane, Rangitiikei, Whanganui, and Ruapehu districts to ‘Red’ on 3 December.¹⁶⁰

4.2.8 Was Cabinet’s decision to rescind its vaccination targets and more rapidly transition to the Protection Framework Treaty compliant?

4.2.8.1 Why have a vaccination target at all?

Cabinet received consistent, clear, expert advice that a high vaccination rate reflected across all population groups was fundamental to the success of the

155. Ministry of Health, ‘More than 21,000 Doses of Vaccine Given Yesterday; 88 People in Hospital – 7 in ICU; 194 Community Cases; 1 Death’, media release, 17 November 2021, <https://www.health.govt.nz/news-media/media-releases/more-21000-doses-vaccine-given-yesterday-88-people-hospital-7-icu-194-community-cases-1-death>.

156. Honourable Chris Hipkins, ‘COVID-19: Implementing the COVID-19 Protection Framework’, Cabinet paper, [22 November 2021], <https://covid19.govt.nz/assets/Proactive-Releases/Alert-levels-and-restrictions/10-Dec-2021/Vaccine-Certificates-and-CPF/COVID-19-Implementing-the-COVID-19-Protection-Framework.pdf>.

157. Document D50, pp 22, 25.

158. *Ibid*, pp 24–26.

159. Document D46, p 11.

160. Document D50, pp 43–47; doc d32(a).

Protection Framework. The very design of the Protection Framework heavily relied on, as it was initially framed, a ‘highly vaccinated’ population. The 90 per cent target per district health board – although not the target Maaori health leaders preferred -- was a way of ensuring a reasonable level of protection for all population groups.

George Whitworth, principal adviser in the COVID-19 Strategy and Policy team at DPMC, acknowledged that modelling supports the ‘notion that more vaccination is obviously better and improves protection for the community as a whole and for the individuals who choose to get vaccinated.’¹⁶¹

Dr Bloomfield told us at our hearing that the vaccination rates in Aotearoa New Zealand were ‘moderate, high and very high’ when compared internationally.¹⁶² We assume Dr Bloomfield’s different categorisation is meant to describe the lower vaccination rate of Maaori as ‘moderate’, with other population groups ‘high’ and ‘very high’. Dr Bloomfield also accepted that this rate for the whole population does not necessarily provide a good level of protection in contiguous communities where vaccination is lower, and that many of those communities have high Maaori populations.¹⁶³

Moreover, we reiterate that in the Prime Minister’s announcement on 22 October, a threshold of 90 per cent for each district health board ‘provides a high level of coverage, keeping most New Zealanders safe and helping slow and control outbreaks, assisting public health authorities to do their job’. She also stated that it would ‘address equity issues’. She said that it was informed by modelling.¹⁶⁴

The 90 per cent vaccination target for each district health board was an agreed upon target for vaccination after discussions of a range of different options that would provide a reasonable level of protection. We note that this target was significantly less onerous than the original Ministry of Health advice, and the conclusions from Maaori public health experts and iwi leaders throughout October. We acknowledge that those leaders also emphasised that a shift to the Protection Framework required strong protections for Maaori, and should not be rushed. Nonetheless, we are satisfied that the 90 per cent threshold for each district health board would go a long way to achieving that goal.

Given the significant likely prejudice to Maaori and to particular Maaori communities, and the Crown’s heightened obligations under the principle of active protection, we sought to understand from the evidence received what could have convinced Cabinet to make a move that could so gravely impact on Maaori.

The rescinding of this measure altogether, however, was even further away from what Treaty partners and its own officials told the Crown, and shed the reasonable level of protection that a target would afford to Maaori and other at-risk population groups.

161. Transcript 4.1.10, p 465.

162. Ibid, p 419.

163. Ibid, p 467.

164. Right Honourable Jacinda Ardern, ‘New COVID-19 Protection Framework Delivers Greater Freedoms for Vaccinated New Zealanders’, media release, 22 October 2021, <https://www.beehive.govt.nz/release/new-covid-19-protection-framework-delivers-greater-freedoms-vaccinated-new-zealanders>.

In attempting to understand Cabinet's reasoning for this more rapid move, we considered whether the risks posed to Maaori by the Alert Level system 'failing', as Crown counsel put it, were significantly great to outweigh the risks posed by moving to the Protection Framework with lower vaccination rates for Maaori. We did not receive evidence that the Alert Level system was 'failing' so significantly in early November – or that the economic and social licence impacts had increased so dramatically – that it would warrant the sudden move to the Protection Framework.

4.2.8.2 Why a more rapid transition to the Protection Framework?

4.2.8.2.1 Waning social licence

The Crown told us that 'social licence' was key to the success of the Alert Level system, and that they were concerned about wavering compliance. It appears the Crown was concerned more for future non-compliance, rather than responding to a critically high level of non-compliance.

We accept that concerns about waning social licence were key to the decision to develop the Protection Framework in late September. However, we did not receive evidence that by mid-November the waning of public compliance was accelerating to a degree so serious that it might justify dispensing with the vaccination threshold. We are not convinced by the evidence before us that wavering compliance was so critically serious in Auckland at that time that it warranted putting Maaori communities at risk.

It appears that, alongside compliance with the rules, Cabinet was also considering social licence from a public health perspective. Minister Hipkins said:

The public health justification for continuing hard lockdowns in the face of very high vaccination rates was withering away (which is to say they were becoming unjustifiable and so unsustainable from a legal point of view and from the perspective of the New Zealand Bill of Rights Act).¹⁶⁵

We do not dispute this. If anything, it supports the argument for a 90 per cent vaccination threshold. We cannot see how this would justify a sudden change in timeframes for implementing the Protection Framework.

4.2.8.2.2 Economic impacts

Among the many factors in waning social licence were concerns about people's livelihoods, and the health of the economy. Again, we appreciate that economic impacts of prolonged lockdowns are a significant consideration, and that any impact would hit Maaori populations the hardest. For those reasons, we understand the need for the Protection Framework more generally.

But it is the sudden change in approach to a more rapid transition to the Protection Framework that is the issue here. We were not provided evidence of any serious, imminent economic impacts that might justify a shift to the Protection

165. Document D32(a), p 5.

4.2.8.2.3

Framework while Maaori vaccination rates were relatively lower and they were thus at greater risk.

Perhaps the economic factor for shifting more rapidly that we have the most information on was the potential loss of jobs, but were not shown evidence of how imminent job losses were. We note that, after an increase in funding on 22 October 2021, the Government was spending up to \$940 million a fortnight on business support.¹⁶⁶ While the general economic impact of lockdowns is indisputable, we did not receive evidence that convinced us there was an imminent, serious economic crisis that made shifting to the Protection Framework and lifting the Auckland border the only option available to the Government.

Even a modest further delay would have given Crown entities and Maaori providers greater opportunity to reach the vaccination threshold the Government originally set for the shift to the Protection Framework. We also emphasise that Maaori will continue to experience economic impacts from public health restrictions, as they are more likely, under the Protection Framework, to be under the 'Red' settings due to lower vaccination rates. In some sense, Maaori communities will continue to be economically punished for Cabinet's failure to approve an equitable vaccine rollout.

In all, these factors – economic impacts and waning social licence – are extremely important for the Government to consider. The National Iwi Chairs Forum, too, acknowledged this when they were consulted on the draft Protection Framework at the beginning of October. However, Maaori always stressed the need to implement the Protection Framework with cautious timing due to inequitable vaccination rates. The Prime Minister herself said the same when she announced the Protection Framework on 22 October.

4.2.8.2.3 Increased protections

The Crown argued that the new framework was still, overall, more protective than the Alert Level system. Crown counsel stated:

the New Framework allows regions to be put at settings for a wider set of reasons than under the Alert Level Framework, which relied on there being COVID-19 in the community or a risk of COVID-19 in the community. Conversely the New Framework allows regions to be put at settings based on vaccination rates, vulnerability of the community and health system capacity.¹⁶⁷

We also considered whether the alternative measures implemented were as equitable and protective as waiting until 90 per cent vaccination rates were reached across all district health boards. Minister Hipkins stated in his evidence that the move away from the threshold was offset by the following protective measures:

¹⁶⁶ Honourable Grant Robertson and Honourable Stuart Nash, 'Business Boost to Transition to New COVID Framework', media release, 22 October 2021, <https://www.beehive.govt.nz/release/business-boost-transition-new-covid-framework>.

¹⁶⁷ Submission 3.3.58, p 13.

- ▶ keeping the Auckland boundary in place for two weeks after the framework came into force, to provide additional time for people to get vaccinated;
- ▶ requiring people moving across the Auckland boundary between 15 December and 16 January to be vaccinated or have had a negative test with 72 hours; and
- ▶ moving particularly vulnerable areas into the ‘Red’ setting initially.¹⁶⁸

Crown counsel argued that ‘these measures all went further than what the public health advice suggested’ about how the Protection Framework should operate, which signalled ‘decision-makers were highly conscious [of] the need to protect Maaori and were taking active steps to mitigate the risk to Maaori’.¹⁶⁹ Crown counsel argued that this ‘suite of protective measures’ struck a ‘balance’ in moving to the framework earlier that acknowledged ‘likelihood of increased risk to unvaccinated Maaori’.¹⁷⁰

4.2.8.2.4 Further funding

We also considered the announcement of the \$120 million Maaori Communities COVID-19 Fund on 22 October, and whether this justified the more rapid move.

Our first point is that while the first part of this fund has been allocated, to date none of the remaining \$60 million for ‘increasing community resilience’ has been spent. We heard from Grace Smit, deputy secretary organisational support for Te Puni Kookiri, that a plan to roll out that funding was only being approved the week that the Auckland border opened.

Regardless, the \$120 million fund was allocated when the shift to the Protection Framework was still predicated on a 90 per cent vaccination threshold per district health board. Despite the threat posed by the opening of the Auckland border on 15 December, without any guarantee Maaori would be adequately vaccinated by that date, no additional funding to assist Maaori providers in their scramble to get their communities vaccinated has been provided.

We did not have time to examine, in detail, the experiences of claimants with each of the different funds approved by Te Arawhiti, Te Puni Kookiri, and the Ministry of Health. But we consider that it is relatively clear that the Government did not approve funds early enough and did not organise them in a way that would get them out to Maaori communities efficiently – in fact, practically all of these additional funds were announced during the Delta outbreak. We acknowledge the evidence from Joanne Gibbs that the funding rollout was ‘frustratingly slow for everybody’.¹⁷¹

However, the \$120 million fund has not addressed the existing issues of accessibility and timeliness of funding. For a start, we note that the fund is coordinated by three agencies. Any money that requires sign-off by three different Ministers is susceptible to delay. As such, the fund was not designed in a way that responded to

168. Document D51, pp 5–6.

169. Submission 3.3.58, p 14.

170. *Ibid*, p 15.

171. Transcript 4.1.10, p 393.

4.2.8.3

the claimants' concerns, which they had articulated to government, about funding not being received fast enough.

Claimants told us that funding, contracts, data, resources, and other support are too slow coming through the district health board processes. Iwi and Maaori providers have had to rely on their own voluntary contributions or financial resources to protect their populations. Contracts and resources were coming through to providers but were ad hoc and late. These delays have put Maaori at substantially more and unnecessary risk. As Simon Royal stated, Maaori providers were forced into 'scrambl[ing] to try and produce the result in real time for their communities'.¹⁷²

It is not enough for the Government to blame district health boards for this issue – they knew that district health boards were ineffective and indeed had decided they should all be disestablished.¹⁷³ We consider the Government should have adopted a more centrally coordinated approach to the funding rollout, with much more support given to the primary health care and whaanau ora providers who would be primarily responsible for the rollout of vaccines to their communities.

4.2.8.3 *Our analysis and findings*

Overall, we consider that a new framework was necessary, but are not satisfied that the more rapid transition adequately took Maaori needs into account.

If the age adjustment had been accepted by Cabinet, the Maaori population, younger and, according to the Crown and Maaori health experts, more susceptible to adverse health conditions by almost every measure, would likely not have been so disadvantaged in the age-based rollout. They would have, proportionate with other population groups, become eligible for the vaccine as early as the rest of the population.

If more Maaori had been eligible for the vaccine earlier, and more funding and resource provided earlier, it seems likely the Protection Framework would have provided a reasonable level of protection for everyone in Aotearoa New Zealand, as it was initially designed to do.

On 7 November, less than a fortnight before the more rapid transition to the Protection Framework was adopted, the Prime Minister defended her government's actions during the Delta outbreak, saying: 'Your suggestion that we have taken decisions that have somehow consciously exposed people to risk is wrong.'¹⁷⁴

The Crown's evidence in this inquiry, including that of Minister Hipkins, shows that in respect of the more rapid move to the Protection Framework, the Government knew it was putting Maaori at risk and moved more rapidly to the

172. Transcript 4.1.10, p 540.

173. Honourable Andrew Little, Honourable Peeni Henare, and Honourable Dr Ayesha Verrall, 'Major Reforms Will Make Healthcare Accessible for All NZers', media release, 21 April 2021, <https://www.beehive.govt.nz/release/major-reforms-will-make-healthcare-accessible-all-nzers>.

174. Right Honourable Jacinda Ardern, interview with Jack Tame, *Q&A*, Television New Zealand, 7 November 2021, <https://www.tvnz.co.nz/shows/q-and-a/clips/pm-ardern-on-the-past-and-future-of-delta-outbreak>.

Protection Framework anyway, relying on mitigation measures that it hoped would be effective.

The summary of the threat posed to Maaori in the joint evidence of public health experts Dr Danny de Lore, Dr Erik Andersen, Dr Teuila Percival, Dr Jin Russell, Dr Owen Sinclair, and Associate Professor Siouxsie Wiles is as follows:

A shift to the COVID-19 Protection Framework, the movement of individuals outside of Taamaki, and any loosening of international borders before Maaori achieve equivalent proportions of vaccination coverage to the broader population will negatively and disproportionately affect the health of Maaori children and their whaanau. Maaori currently have the lowest proportions of vaccination coverage of all major ethnic groups in Aotearoa. According to the Ministry of Health at the time of writing (as of Tuesday 23rd November 2021), 64.3% of eligible Maaori have been administered two vaccine doses, compared to 78.9% of Pacific Peoples, >95% of Asian, and 84.1% of European/Other ethnicity. Comparing the second doses administered figures given by the Ministry of Health with the 2018 census data gives a proportion of the total population double vaccinated as 74.9%, and the proportion of the Maaori population double vaccinated as 47.6%.

In addition to national vaccination rates, the proportion of eligible Maaori vaccinated at a local community level must also be considered. If SARS-COV-2 were to be present in a particular local area, it is the vaccination rates within that community and not the regional or national vaccination rate that is important for protecting the community from COVID-19.¹⁷⁵

The Maaori Communities COVID-19 Fund, as a last-ditch effort to try to mitigate known risks with a transition to the Protection Framework, is insufficient. It was an exceptionally risky strategy, given the well-established pressure the health system and Maaori providers were already under. Further, the risks were exacerbated by making it a contestable fund during an emergency. As Ms Walker argued, ‘the risk to Maaori lives cannot be ameliorated by \$120 million.’¹⁷⁶

These failures are compounded by the fact that the fund was already too late to meaningfully solve a problem that had been obvious for most of 2021. Further, the fund was announced while there was still a vaccination threshold for triggering the Protection Framework, which at least allowed for the possibility of more time for the vaccination campaign if Maaori needed it.

We asked Minister Hipkins whether Cabinet accepts that, if a comparable vaccination rate for Maaori is not achieved, this would put Maaori at inequitable risk. He said:

If unvaccinated Maaori were willing to be vaccinated but unable to access vaccines because of existing inequities in the health system, or owing to a range of

175. Document D8(a), pp7–8.

176. Transcript 4.1.10, p570.

4.2.8.3

socio-economic factors such as access to transport, then the Crown would accept there may be an inequitable risk of getting COVID and having worse outcomes. It is too soon to assess this matter as the vaccination effort continues.¹⁷⁷

Further, Minister Hipkins said that, to his knowledge, Cabinet did not specifically consider ‘the capacity of the Maaori residential disability services or the disability sector more generally in relation to COVID-19 or the decisions to move to the New Framework.’¹⁷⁸

As we have already said, we consider that a key barrier in access to the vaccine was the Crown’s inequitable prioritisation of the vaccine rollout. In abandoning the vaccination threshold, the Crown undermined the Maaori Communities COVID-19 Fund’s effectiveness as a tool for the transition. Approving a mitigation payment to make the known risk to Maaori less severe did not solve the disadvantage the Crown had created through its inequitable vaccination programme, and its more rapid shift to the Protection Framework.

In making this move, Cabinet is in large part responsible for exacerbating the pressure that Maaori providers are under to carry the vaccination effort for their people, under a fixed, unrealistic timeframe, and high expectations from their communities that their needs will be met.

Further, we note that while many witnesses were optimistic about the Maaori vaccination drive overall, none of them told us that achieving an equitable vaccination rate before the Auckland border opened was possible. At the time of writing, that has still not been achieved. In summarising the threat to Maaori posed by the more rapid transition, Andrew Sporle told us:

the existing vaccination program cannot address the deficit in Maaori vaccination coverage at the required pace to equitably protect Maaori from the largest threat to public health in a century. The number of Maaori to be fully vaccinated within the next few weeks requires the application of all available resources in the most efficient means practicable in order to achieve the level of protection for Maaori that the Prime Minister’s stated goal of ninety per cent coverage would provide.¹⁷⁹

We find that Cabinet’s decision to transition to the Protection Framework on 15 December, without the original district health board vaccination threshold:

- ▶ puts Maaori at disproportionate risk of Delta infection when compared with other population groups, in breach of the principles of active protection and equity;
- ▶ puts Maaori health and whaanau ora providers under extreme pressure and undermines their ability to provide equitable care for Maaori, in breach of the principles of tino rangatiratanga and options; and

177. Document D51(a), p 4.

178. Ibid, p 10.

179. Document D3, p 4.

- ▶ was made despite the strong, unanimous opposition of the Maaori health leaders and iwi leaders it consulted, in breach of the principle of partnership.

4.2.9 Was Cabinet receiving good-quality advice about its Treaty obligations?

Section 14 of the Public Service Act 2020 partly states:

- (1) The role of the public service includes supporting the Crown in its relationships with Maaori under the Treaty of Waitangi (te Tiriti o Waitangi).
- (2) The public service does so by the Commissioner, public service chief executives, interdepartmental executive boards, and boards of interdepartmental ventures having responsibility for—
 - (a) developing and maintaining the capability of the public service to engage with Maaori and to understand Maaori perspectives;

We saw evidence of Treaty-compliant advice being provided by key Treaty relationship agencies Te Arawhiti and Te Puni Kookiri; however, the Cabinet papers did not reflect this advice. In fact, the Treaty Analysis sections of the Cabinet papers commenced with a disclaimer-type statement that the Treaty does not require the Crown to adopt a particular path, and that Treaty obligations are only required to be abided by to a reasonable degree.

As another example, Cabinet was advised that the principle of active protection is relevant in the consideration of vaccination-related policy, and that it means active protection of Maaori health interests. The advice did not consistently or adequately consider a number of the Treaty principles and their relevance to the situation, including:

- ▶ the principle of partnership and the importance of meaningful engagement in respect of policy design;
- ▶ the principle of tino rangatiratanga and the active protection of the rights of Maaori to design and deliver culturally appropriate services for their people; and
- ▶ the principle of equity and the importance of designing policy with Maaori that will achieve health equity for Maaori.

The prevailing impression we get of officials' understanding of active protection is that any measure that might be considered 'protective' satisfies that principle. We questioned Ms Fairhall, for example:

Q: At paragraph 50 you state that DPMC heard from public health experts who said the protection framework should be Tiriti based with an explicit goal to save Maaori lives. Would you describe the protection framework in these terms as it stands?

A: So the protection framework as part of the overall minimising of protection approach which is designed to reduce the number of people who are sick and die including the number of Maaori who become sick and die as well.¹⁸⁰

180. Transcript 4.1.10, p 463.

We consider that Cabinet is therefore not consistently making decisions with the benefit of key advice from its own expert agencies. We observe that in this inquiry, we see this reflected in some of the policy outcomes. Although Cabinet papers mentioned the Treaty, it did not mean DPMC put Treaty-compliant recommendations up to Cabinet.

Based on the evidence before us, we are not convinced that DPMC staff have adequate capability in incorporating Treaty analysis into their policy advice to Cabinet. The Cabinet papers we reviewed often revealed a misapprehension of the Treaty principles of active protection and equity. It appears that officials thought that any measure seen as generally protective of Maaori would mean the Government would satisfy its obligations under active protection. This does not adequately reflect the urgency and active effort required under the principle of active protection.

In his answers to our question about this, Minister Hipkins said:

I cannot breach Cabinet confidentiality, but I can say that my ministerial colleagues and I are well aware of the Crown's Treaty obligations and the relevant principles of the Treaty – irrespective of whether and how these principles are set out in various Cabinet papers and other advice that came before us.

In relation to the principles of partnership and tino rangatiratanga, for example, Cabinet was aware of the full range of kaupapa Maaori outreach services the Crown had agreed to fund and support and who, through the iwi leaders pandemic response group and others, had made it clear that by Maaori for Maaori services were far and away the most effective way to reach those whom to this point had not engaged with the mainstream health system, DHBS, or PHOS.¹⁸¹

We understand Te Arawhiti's desire to build the capability of the whole public service by encouraging policymakers to do their own Treaty analysis.¹⁸² Nonetheless, Te Arawhiti has the expertise to quality-assure ministerial and Cabinet advice in the same way that other agencies do for their areas of responsibility and expertise.

We suggest the Crown seek to build public service capability in this area.

4.3 MAAORI–CROWN ENGAGEMENT THROUGHOUT THE PANDEMIC RESPONSE

4.3.1 The need for quality engagement between the Treaty partners

Engagement and relationships were critical for iwi and communities, and for Maaori service providers, in planning the Maaori pandemic response. In turn, as we established in chapter 3, the Crown also needs to practise a high standard of engagement, in terms of consistency and quality of engagement and recognising the value of each other's contributions.

181. Document D51(a), p 5.

182. Transcript 4.1.10, pp 492–493.

4.3.2 Maaori views of engagement

The claimants and interested parties presented a varied account of engagement with the Crown since the beginning of the pandemic response in earnest in March 2020. The evidence provided by inquiry participants indicated that engagement varied, and at times was non-existent. During the Delta outbreak, the parties' experience of engagement was, broadly, unsatisfactory.

In its closing submissions, the New Zealand Maaori Council asserted that 'the Crown could have worked with Maaori, and properly funded Maaori health providers, to avoid, or at least lessen, the impacts of its decisions'. The New Zealand Maaori Council said that the Crown had failed to engage with Maaori until 'very recently' and even then, it had done so in an 'ad hoc and haphazard fashion'.¹⁸³

Michael Smith, the director of Ihirangi Trust, co-chair of the Climate Change Iwi Leaders Group, and a member of the Iwi Pandemic Response Group within the National Iwi Chairs Forum, presented evidence on behalf of the New Zealand Maaori Council. He outlined a number of hui early in 2020, where the National Iwi Chairs Forum Iwi Pandemic Response Group met with Minister Kelvin Davis twice a week.¹⁸⁴ These regular meetings gave the Iwi Pandemic Response Group the opportunity to organise supplies and resources to be directed to Maaori communities. Mr Smith noted that '[w]e were not asked to provide any policy advice, because at that stage, the Government was mainly taking advice from experts in public health and epidemiology'.¹⁸⁵

Before the arrival of Delta in Aotearoa New Zealand, in June 2021, the National Iwi Chairs Forum Iwi Pandemic Response Group attempted to reactivate the regular engagement they had with the Government in 2020. Mr Smith said: 'This time, however, the Government was not in a rush to engage or work with us to the same level as previously. Things seemed to stumble along until Hon Kelvin Davis formally terminated the agreement'.¹⁸⁶

When the Delta variant was detected in August 2021, the Government re-engaged with the National Iwi Chairs Forum Iwi Pandemic Response Group. Meetings between the Pandemic Response Group, the Minister, and other government officials occurred regularly, as they had throughout 2020. However, the nature of the engagement had changed. Mr Smith told us that the advice provided to government as part of this regular consultation was consistently ignored, with the Iwi Pandemic Response Group's expertise on how to reach Maaori communities neither recognised or acknowledged.¹⁸⁷ The Iwi Pandemic Response Group raised concerns about:

- ▶ Maaori vaccination rates;
- ▶ the impact of the Government's traffic light framework on Maaori communities;

183. Submission 3.3.50, pp 1–2.

184. Document D11, p 2.

185. Ibid.

186. Ibid, p 3.

187. Ibid.

4.3.2

- ▶ low vaccination rates in Te Tai Tokerau;
- ▶ the transmission rate of COVID-19;
- ▶ the protection of regional communities; and
- ▶ the distribution of financial assistance.¹⁸⁸

Mr Smith said he felt like the Pandemic Response Group was ‘consulted with as a form of therapy, that maybe we’d feel better if we’d been talked to . . . but it certainly wasn’t the best practice standards generally accepted internationally [of] full informed and prior consent [and] engagement on a Treaty partnership level.’¹⁸⁹ Despite this consultation, the advice provided was ‘consistently ignored’.¹⁹⁰ Mr Smith characterised this engagement failure between the National Iwi Chairs Forum Iwi Pandemic Response Group and the Government as a lack of partnership.¹⁹¹

Peter Fraser, the national secretary for the New Zealand Maaori Council and representative in terms of Crown consultation, referred to several recent unsuccessful attempts to engage with the Government.¹⁹² He noted, with regard to discussions concerning the Protection Framework, that:

- ▶ the New Zealand Maaori Council was not invited to hui;¹⁹³
- ▶ the New Zealand Maaori Council was not provided with any information by the Crown prior to those hui;¹⁹⁴ and
- ▶ if the hui were intended to be a consultation process, it was a highly unsatisfactory one.¹⁹⁵

Mr Fraser defined ‘[g]enuine and meaningful consultation’ as requiring

the Crown to be open to change or modify the proposal it is consulting on as a result of information provided during the consultation process. This was not the approach of the Crown during these hui. Ministers made it clear that the Government had already decided what it was going to do.¹⁹⁶

The New Zealand Maaori Council went on to send a letter to Prime Minister Jacinda Ardern raising its concerns. The New Zealand Maaori Council did not believe the Prime Minister’s response was sufficient, and stated:

The Prime Minister’s response did not recognise or treat Maaori as a Treaty partner; instead, the Prime Minister addressed the adverse impacts of the [COVID-19

188. Document D11, pp 3–4.

189. Transcript 4.1.10, p 61.

190. Document D11, p 3.

191. *Ibid*, p 5.

192. Document D9, p 7.

193. *Ibid*, pp 1–2.

194. *Ibid*, p 2.

195. *Ibid*, p 3.

196. *Ibid*, p 3.

Protection Framework] and COVID-19 upon Maaori as a factor for the Crown to balance against the impacts on the wider population.¹⁹⁷

The New Zealand Maaori Council asserted that the Prime Minister's letter failed to engage with it according to its statutory mandate as a Treaty partner. Instead, Peter Fraser said that the Council was treated as 'yet another community group.' Mr Fraser closed his affidavit with the following comment:

The Crown has not accepted or adopted the advice given or responded to the concerns raised by Maaori leaders at engagement hui regarding the [COVID-19 Protection Framework]. Rather, the Crown specifically rejected all our attempts to engage with them on a Protection Framework with potentially disproportionately negative and irreversible impacts upon Maaori.¹⁹⁸

Overall, the New Zealand Maaori Council argued that the Crown's engagement with Maaori groups on the COVID-19 response had come too late, and to the extent that it had occurred, it was disorganised.

Dr Rawiri Jansen, the clinical director networks and integration for the National Hauora Coalition and co-leader of Te Roopuu Whakakaupapa Urutaa, said that in his experience even the engagement in 2020 was poor. He described that in the initial stages of the COVID-19 pandemic, the National Hauora Coalition began to engage through a range of channels to offer guidance and direction to the Crown to prevent the impacts of COVID-19 from disproportionately affecting Maaori. He noted that despite these early efforts, 'the Crown persistently dismissed or delayed to engage and resource Maaori.'¹⁹⁹ This did not stop Maaori from continuing their protection efforts, with Dr Jansen providing copies of media articles relating to various Maaori-led responses to COVID-19.²⁰⁰

Dr Jansen provided an example of a lack of engagement where Te Roopuu Whakakaupapa Urutaa set out recommendations to 'breathe life' into the Crown's Maaori Response Action Plan in April 2020, describing that: 'Most of Te Roopuu Whakakaupapa Urutaa's recommendations at that time were not and have not been adopted by the Government, [while] others were incompletely, belatedly or inadequately adopted.'²⁰¹

Regarding engagement in 2021, counsel for Te Ora, in their closing submissions, echoed the New Zealand Maaori Council, noting:

The Crown's response has been haphazard and disjointed with regard to engagement with Maaori. Despite Maaori efforts to provide solutions and resources to the

197. Ibid, p 6.

198. Ibid, p 8.

199. Document D39, p 7.

200. Ibid.

201. Ibid, p 12.

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Crown in an effort to mitigate inequities caused by the Crown's COVID-19 response, the Crown has persistently dismissed this advice OR delayed in engaging and resourcing Maaori.²⁰²

The disjointed approach of the Crown to the COVID-19 pandemic was also mentioned in the closing submissions on behalf of Te Roopuu Taurima o Manukau Trust, who expressed that in order to give proper effect to the principles of the Treaty, the Crown 'needs to do its part to work in partnership with Maaori by adopting an inclusive rather than ad hoc approach to consultation and engagement'.²⁰³

The National Hauora Coalition, in their closing submissions, noted that an aspect of the Crown's engagement failure included the Crown's choice to selectively engage with only a few Maaori organisations, leaders, and stakeholders. Counsel for these groups asserted that consultation requires more than mere communication with any Maaori, but confirmation that communication is being had with appropriate groups whose koorero is reflected in the design of policy decisions.²⁰⁴ This was also a concern raised by Ngaati Hine, Te Kapotai, and Ngaati Pare, who said perspectives they communicated to government are not reflected in policy decisions.²⁰⁵

Te Roopuu Waiora Trust, representing taangata turi (Maaori deaf), noted that they were not engaged at all by the Crown. Indeed, Te Roopuu Waiora Trust expressed that they had not been engaged with by the Crown about either the vaccination programme or the pandemic response.²⁰⁶ Te Roopuu Taurima, the largest kaupapa Maaori disability support service, also reportedly were never engaged with by the Crown. Tania Thomas, the manawhakahaere/chief executive officer of Te Roopuu Taurima, stated that as there was no engagement with Te Roopuu Taurima she doubted whether there was engagement with other similar groups.²⁰⁷

Overall, the claimants and interested parties characterised the engagement efforts of the Crown as inconsistent. They saw this inconsistency as falling short of the promise of partnership enshrined in the Treaty.

4.3.3 The Crown's view of engagement

In closing submissions, Crown counsel rejected the characterisation that the Crown's consultation was perfunctory and insincere.²⁰⁸ He argued that, viewed 'in the round', the Crown's consultation and engagement, both nationally and at a regional level, were significant.²⁰⁹ The Crown drew attention to the fact that engagement 'is a difficult balance to strike' and that 'things are not always perfect'.

202. Submission 3.3.59, p 3.

203. Submission 3.3.56, pp 1–2.

204. Submission 3.3.57, p 12.

205. Submission 3.3.55, p 6.

206. Submission 3.3.54, p 9.

207. Document D31, pp 5–6.

208. Submission 3.3.58, pp 15–16.

209. Ibid, p 15.

However, Crown counsel noted that claimant witnesses said there was both ‘too much and too little talking.’²¹⁰

Lil Anderson noted that Te Arawhiti ‘works to support other agencies to ensure that public sector engagement with Maaori is meaningful’ and that it also leads the Statement of Engagement with the National Iwi Chairs Forum.²¹¹

Ms Anderson described that from the moment Aotearoa New Zealand shifted into Alert Level 4 in August 2021, Te Arawhiti utilised its established relationships and connections to ‘stand up a network for iwi and other Maaori leadership groups to engage on both an individual well-being level and on live issues facing their whaanau, communities and regions.’²¹² In addition to the individual well-being calls conducted by Te Arawhiti staff, Ms Anderson noted that senior Ministers and officials also engaged with iwi/Maaori across Aotearoa New Zealand in a variety of fora.²¹³ She asserted that these hui provided a critical avenue for iwi and other Maaori leadership to bring challenges and issues to the attention of Ministers and other agencies. She also said that engagement had been almost ‘constant’ during the last few months, as it ‘has had to feed into the Cabinet process.’²¹⁴

As discussed earlier in this chapter, on 15 November Cabinet decided to abandon the 90 per cent district health board-by-district health board vaccination threshold for entering the COVID-19 Protection Framework. On 17 November, prior to the Prime Minister’s public announcement of this decision, Lil Anderson called iwi leaders to give them a ‘heads-up.’²¹⁵ She said:

I can say those were very tough calls to make and iwi responded in a way I think we all expect they would, they were disappointed, they were angry, they were frustrated and they wanted to understand what sat behind the decision, they wanted to understand what it meant for them going forward. So at the end of those calls, they were very quick calls you know there was myself and I think you know the iwi leaders on the call, they were about 5 minutes in length and we ended the call by talking about re-connecting to be able to work through the readiness component. We relayed those conversations up through our minister’s office, I think I said they were rough and he made that known to cabinet as I understand it.²¹⁶

Subsequently, Ministers and officials conducted hui with these leaders over the next week to discuss the issues arising from that announcement and provide ongoing commitment to practical support. These hui took place between 19 and 23 November, and the National Iwi Chairs Forum expressed strong concerns about ‘the Framework coming into force earlier than expected, spread of the virus by relaxing the Auckland boundary, and the risks to Maaori health’ given vaccination

210. Ibid, p16.

211. Document D46, p1.

212. Ibid, p2.

213. Ibid, p3.

214. Transcript 4.1.10, p 494.

215. Document D46, p10.

216. Transcript 4.1.10, p 497.

4.3.4

rates. They sought ‘strong involvement in regional decisions and actions to prepare their communities.’²¹⁷

We questioned Grace Smit as to whether the Government had made every effort to partner and protect Maaori through its vaccination rollout and the Protection Framework. She responded:

I think there has been some evidence this week that perhaps there are some gaps in that and that we could have done better. I do think that looking back you have the ability to see where and at what point things may have been missed or may have done in too rushed a fashion.²¹⁸

At our hearing, Ruth Fairhall reflected on the notion that more could have been done when questioned about whether Cabinet had made every effort to partner and protect Maaori, through the vaccination rollout and design implementation of the Protection Framework. She said that ‘there’s always things we could do better.’²¹⁹ In the Crown’s closing submissions, Crown counsel noted that from the outset of the inquiry, the Crown has expressed ‘a desire to improve and learn.’²²⁰

4.3.4 Was the Crown’s engagement with Maaori throughout the pandemic response Treaty-compliant?

As established in chapter 3, the requirement for the Crown to partner with Maaori is especially relevant where Maaori are expressly seeking an effective role in the process, and is heightened where inequities in outcomes exist.²²¹ At various points, Maaori groups attempted to engage with the Crown throughout the course of the pandemic, to offer their expertise and in recognition that the impact of COVID-19 could disproportionately fall upon Maaori.

The problem with engagement between the Crown and Maaori was never that Maaori voices were not sufficiently organised or vocal. Indeed, many Maaori groups engaged with the Crown at the highest level, including the Iwi Chairs Pandemic Response Group, the New Zealand Maaori Council, the Whaanau Ora Commissioning Agency, the National Hauora Coalition, and iwi groups.

Te Roopuu Whakakaupapa Urutaa is an example of a Maaori group with a clear agenda and undisputed public health expertise. The group was formed in March 2020 to provide an independent Maaori voice to hold the Government to account throughout the course of the pandemic.²²² The roopuu, alongside several other groups, led nationwide discussions to remind decision makers of their responsibility to Maaori.²²³

217. Document D46, p 11.

218. Transcript 4.1.10, p 506.

219. Ibid, p 461.

220. Submission 3.3.58, p 1.

221. Waitangi Tribunal, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Lower Hutt: Legislation Direct, 2019), pp 28–29.

222. Document D39, p 8.

223. Ibid, p 10.

Indeed, Te Roopuu Whakakaupapa Urutaa, along with iwi and Maaori leaders, consistently stressed that the sequencing framework should be developed with Maaori, and that the Crown needed to make sure Maaori were not put at an inequitable risk of infection as a result of the framework.

As mentioned earlier in this chapter, Ms Anderson outlined that Te Arawhiti had provided commentary on draft Cabinet papers to this effect, and recommended 'that Maaori have significant involvement in the design of the vaccination rollout sequencing, reflecting the level of Maaori interest in the proposals'.²²⁴

This partnership was never implemented. There was no pressing or emergency situation in the early part of 2021 that might have prevented the Crown from engaging fulsomely – in fact, as the vaccine rollout began, there were zero community cases. We find that the Crown's failure to jointly design the vaccine sequencing framework breached the Treaty guarantee of tino rangatiratanga and the principle of partnership.

As for engagement and partnership efforts more broadly, we do not doubt some Ministers and government officials exhibited goodwill and good intentions. Some Ministers made positive commitments in their discussions with iwi, hapuu, and other Maaori collectives. As discussed earlier, on one occasion, Maaori Ministers took these commitments into Cabinet, and at least initially managed to persuade Cabinet to make decisions that would go some way to protecting Maaori interests.²²⁵ The expert advice and efforts of Te Arawhiti and Te Puni Kookiri officials is clear. We acknowledge their perseverance, despite the fact their advice was not consistently reflected in Cabinet decisions.

Crown–Maaori engagement has clearly been inconsistent. While consultation and hui may have taken place, we could not see a consistent standard for engagement. In addition, we could not see a strong commitment from the Crown to co-design and power-share in a way that would have met its partnership duty under the Treaty. Evidence presented to us suggested that the claimants and interested parties felt as if Crown actions were predetermined.²²⁶ If true, this undermines the purpose of engagement and the central promise of partnership articulated in the Treaty.

When considering the partnership threshold, Crown goodwill and the promise to learn and grow is not the Treaty standard.²²⁷ Because the power imbalance in the partnership between Maaori and the Crown favours the Crown, it is the Crown's responsibility to ensure Maaori are not disadvantaged in the relationship.²²⁸ This includes ensuring Maaori can exercise self-determination in the design, delivery, and monitoring of health care.²²⁹ Moreover, the Crown must actively ensure that Maaori – through iwi, hapuu, or other organisations of their choice – can exercise

224. Document D46, p 7.

225. Document D46(a).

226. Document D9, p 3.

227. Waitangi Tribunal, *Hauora*, p 28.

228. *Ibid.*

229. *Ibid.*, p 163.

decision-making power over their affairs.²³⁰ It cannot just receive advice from Maaori as it would that of another ‘interest group’.²³¹

In particular, we note that a lot of the groups we heard from did not have a lot of resources, or time, to dedicate to engagement; regardless, they viewed it as critically important, and invested in a relationship with the Crown because they knew it was essential to the pandemic response. The fact that the Crown did not always reciprocate does not reflect the Treaty relationship.

In the context of this health emergency, what is reasonable in the circumstances is a robust partnership to the fullest extent practicable. Again, we recognise that in some limited circumstances, due to the imminent nature of a threat and the corresponding need for decisiveness to protect Maaori and others’ interests, this may not be possible. But in acting with urgency in an extraordinary circumstance, there is no room for ad hoc or tokenistic arrangements between Treaty partners. Crown counsel argued that the Treaty principles have been a consideration of the Crown at every step of the pandemic.²³² The outcomes we see now seem to reflect that, in many instances, ‘consideration’ is where the Crown determined its Treaty obligations ended. If the Crown had adequately considered its Treaty obligations, we would expect it to result in Treaty-compliant decisions.

We find that the Crown did not consistently engage with Maaori to the fullest extent practicable on key decisions in its pandemic response. Further, the nature of its engagement was often one-sided, and as a result sometimes disrespectful. These omissions are in breach of the principle of partnership.

4.4 TINO RANGATIRATANGA OF HAUORA MAAORI

During our inquiry, we heard extensive evidence about the ongoing challenges faced by service providers. Earlier in this chapter, we found that the enormous pressure on providers is partly a result of Crown Treaty breaches in respect of the vaccine rollout and the rapid transition to the Protection Framework. In addition, lack of funding and equity of access to data has constrained Maaori service providers’ ability to deliver good outcomes for Maaori.

The lack of appropriate supports for Maaori providers came in the context of the Crown knowing that the work of Maaori service providers would be a lynchpin of the vaccine rollout, as we heard from Dr Bloomfield and Ms Gibbs. Crown evidence shows the Government has known for a long time that it would need to rely heavily on Maaori health and social service providers in order to ensure the vaccination programme was successful. Maaori health and social service professionals were confident they could best provide for Maaori, and consistently made this clear to the Crown.

In this section, we summarise the experiences and successes of the providers who provided evidence for this inquiry. Even in the absence of appropriate

230. Waitangi Tribunal, *Hauora*, p 30.

231. Document D9, p 8.

232. Submission 3.3.58, pp 7–8.

support from the Government, taangata whenua have demonstrated strong commitment to supporting Maaori throughout the COVID-19 pandemic and the Delta outbreak. As resources and funding for Maaori primary health and social service providers increased measurably from August 2021 onwards, they were able to achieve impressive results. Between 6 October and 9 December, Maaori health providers ‘vaccinated over 152,000 Maaori, a 54.7% increase, twice the national increase of 27.1%.’²³³ This indicates that if more Maaori had been eligible earlier, and more funding and resource provided earlier, there would likely not have been the lag in vaccination rates that we see now. In fact, largely due to the efforts of Maaori providers, Maaori vaccination rates are now accelerating at such a pace that the 20 per cent inequity is closing fast.²³⁴

Dr Bloomfield, Ms Fairhall, and other senior government officials recognised these efforts, and described models of care implemented by Maaori throughout the pandemic as ‘innovative’. While these may be novel and innovative from the Government’s perspective, they are ‘normal’ models for Maaori. Whaanau-centred, kanohi ki te kanohi, whakangaahau, whanaungatanga, and mana tangata principles and models are normal practices within Maaori society, and the models that we see being implemented by Maaori come from these principles.

4.4.1 Te Roopuu Waiora (South Auckland)

Tania Kingi, Dayna Tiwha, and Tauri Lyndon provided evidence based on their experiences with Te Roopuu Waiora, a kaupapa Maaori whaanau hauaa organisation based in South Auckland, and the only entity in Aotearoa New Zealand governed entirely by Maaori experiencing physical, sensory, and intellectual disabilities.²³⁵

Ms Kingi explained that the lack of a disability vaccination strategy and the absence of comprehensive data to identify whaanau hauaa has created a lag in Maaori-disabled vaccination rates.²³⁶

She recorded that the initial lockdown in March 2020 placed extreme pressure on the disability sector. Whaanau hauaa were confused by the complex, inaccessible information provided by Government; and lack of adequate supports meant many whaanau had no choice but to assume the role of carers without knowledge or training.²³⁷

Later in the pandemic, Te Roopuu Waiora launched Paerangi, a unique digital platform aimed at providing accessible COVID-19 information in easy English, New Zealand Sign Language, and te reo Maaori, which taangata turi had given them positive feedback on.²³⁸ Ms Kingi’s evidence indicated the success of Paerangi’s outreach: ‘after the first month of going live, 58,000 visits to Paerangi

233. ‘Maaori Communities Covid-19 Fund’, Te Puni Kookiri, <https://www.tpk.govt.nz/mi/whakamahia/covid-19-information-for-maori/maori-communities-covid19-fund>, last modified 16 December 2021.

234. Submission 3.3.58, p 10.

235. Submission 3.3.54, p 1.

236. Document D30, p 11.

237. Ibid, p 8.

238. Document D6, p 3.

were registered . . . show[ing] that accessible, culturally relevant COVID-19 information was being sought not only by whaanau hauaa but the wider Maaori and disability community.’²³⁹

In October 2021, Te Roopuu Waiora coordinated Awahou, a vaccination strategy for whaanau hauaa in South Auckland. This major initiative brought together 12 whaanau ora providers, disability support services, and community health organisations.²⁴⁰ Through providing accessible information and lifting community engagement, Awahou has ensured whaanau hauaa can more successfully engage with providers however and whenever they need.²⁴¹ At the hearing, Ms Kingi told us that they had worked alongside 120 vaccinators in two months in an effort to dismantle the barriers to vaccination.²⁴² Mr Lyndon’s evidence highlighted that educating vaccinators and upskilling carers is key to the strategy, and this is an ongoing commitment:

Whaanau hauaa members like Dayna and myself hold Zoom hui with the vaccination staff and Maaori providers, to help them understand our communities. It is important to understand our experiences and what works best directly from us. We have held these Zoom hui multiple times a week since the start of October.

We have discussed the differences between hearing impaired, Deaf and Deaf plus communities, and how to best engage with these communities. We have also discussed mask alternatives like plastic shield barriers and how to uphold the mana of our Turi whaanau.²⁴³

Haamiora Te Maari, a board member and vice president of Tu Taangata Turi, told us that ‘the information provided by the government on COVID-19 has been overwhelming.’²⁴⁴ Karen Pointon, a support worker with the community-based disability service provider Community Connections Supported Living Trust, also emphasised that one of the main barriers for taangata turi has been accessing COVID-19 information and vaccinations because of the lack of culturally and linguistically accessible information, which has exacerbated vaccine hesitancy.²⁴⁵ (We discuss vaccine hesitancy in more detail later in this chapter.) Ms Pointon highlighted multiple barriers that taangata turi have had to contend with, including isolation and the lack of funding for trilingual interpreters and resources.²⁴⁶

In response to the absence of accessible New Zealand Sign Language information, taangata turi developed a New Zealand Sign Language video on COVID-19 issues in collaboration with experts such as Associate Professor Siouxsie Wiles.²⁴⁷

239. Document D30, p 10.

240. Ibid, pp 11–13.

241. Transcript 4.1.10, p 262.

242. Ibid, p 269.

243. Document D6, p 3.

244. Document D5, p 2.

245. Document D29, p 22.

246. Transcript 4.1.10, pp 248–249.

247. Document D29, pp 2–33.

Ms Pointon emphasised that networking and relationship-building is core to their work, particularly as many taangata turi do not have access to technology. However, this has meant working voluntarily on top of their existing commitments to successfully support taangata turi.²⁴⁸

4.4.2 Te Roopuu Taurima o Manukau Trust (National)

Te Roopuu Taurima o Manukau Trust is the largest disability support provider in Aotearoa New Zealand. Tania Thomas, the manawhakahaere (chief executive officer), gave evidence on the organisation's efforts to bridge the gaps caused by the lack of accessible information for Maaori with mental health or intellectual disabilities. Ms Thomas said:

When information has been provided, it is often too clinical and needs to be translated into a format that Maaori, and Maaori with intellectual impairments in particular, can understand. We have to check and confirm that the information applies to disability support workers, search for the relevant information, turn it into plain English, set up a range of different processes to share that information (such as paanui, Zoom hui, online consultation hui, creating social media posts, utilising telephone trees) and having face to face hui with managers in residential settings.²⁴⁹

The trust has also worked alongside fellow Maaori health service providers to support whaanau with co-morbidities. This includes collaborating with Turuki Health to establish surveillance testing and establishing a programme in conjunction with Te Hononga Maaori District Nursing Service to enable taangata to receive booster shots.²⁵⁰ This meant having to task additional work to an already overburdened workforce due to staffing shortages, on top of continuing to run business as usual.²⁵¹

4.4.3 Te Puna Ora o Mataatua (Eastern Bay of Plenty)

Two senior leaders at Te Puna Ora o Mataatua, Lee Colquhoun (manahautuu mahi/chief operational officer) and Shelley Cunningham (mana whakahaere tuarua/deputy chief executive), also detailed the work they have been doing as part of the pandemic response. Te Puna Ora is the largest regional health provider for the Eastern Bay of Plenty, with a total of 96 staff, over 400 support workers, over 1,200 direct clients, and over 2,600 registered patients.²⁵² Mr Colquhoun and Ms Cunningham described how Te Puna Ora's ability to respond to the COVID-19 pandemic had been hindered by the rejection of their efforts to adopt a flexible, whaanau ora approach to vaccination services, in particular for those living in rural communities. They noted:

248. Ibid, p 44.

249. Document D31, p 11.

250. Ibid, p 13.

251. Ibid, p 13.

252. Document D43, para 16.

4.4.4

Te Puna Ora's view is that providers need to take services to the communities they are trying to reach, in order to address inequities. As the Eastern Bay of Plenty is one of the more deprived areas in Aotearoa, it is even more important that regional and localised approaches are implemented, to reduce inequities that already exist. Our initial COVID-19 response, which involved a two-pronged approach of fixed and mobile swabbing sites, reflected that (and continues to do so). Our response also incorporated our whaanau ora approach.²⁵³

Mr Colquhoun and Ms Cunningham outlined that they were repeatedly told they could not take a mobile and integrated approach and therefore received minimal government funding. In addition, senior staff members had to assume additional responsibilities, further impacting staffing capacity to provide wraparound care.²⁵⁴ Further, we heard that the main barrier to efficient and effective vaccination delivery was the high bar required to gain cold chain storage accreditation early in the vaccine rollout. From March to June 2021, Te Puna Ora had to operate from a fixed site, having to turn away eligible Maaori as they did not have the capacity to store more than 30 vaccines per day.²⁵⁵

Te Puna Ora recognised the need to tailor services, such as the development of care plans, to the needs of Maaori communities and in the absence of data, conducted Tirohanga Oranga o Mataatua – the COVID-19 Maaori in Mataatua Rohe Survey.²⁵⁶ The survey results confirmed the need for kaupapa Maaori services based on mobile clinics. Mr Colquhoun and Ms Cunningham told us that despite these challenges, as of November 2021, Te Puna Ora was successfully operating five mobile units to service hard-to-reach communities.²⁵⁷

4.4.4 Ngaati Hine Health Trust (Northland)

The Ngaati Hine Health Trust is the largest Maaori health provider in Te Tai Tokerau, serving the mid-North through to Whaangaarei/Ruakaakaa. We heard about the work of the Ngaati Hine Health Trust during our hearing week from Rowena Ngaio Tana, Pita Tipene, and Geoff Milner. Further evidence about their work was also provided to us from Waihoroi Shortland, Moe Milne, and Pamela-Anne Ngohe-Simon.

As the chairperson of the Ngaati Hine Health Trust, Rowena Ngaio Tana described how delays in support and resourcing affected the ability of the trust to reach whaanau. She noted:

as an organisation we are constantly on the back foot trying to overcome the barriers put up by the preferences and operation of central government and the DHB. If I was to characterise generally how we have had to operate during the pandemic, we have

253. Document D43, para 31.

254. Ibid, paras 33, 82–83.

255. Ibid, para 53.

256. Ibid, paras 37–38.

257. Ibid, para 57.

had to find our own way to meet the needs of our people until support trickles down through the system.²⁵⁸

She concluded that systemic barriers and delayed support ultimately resulted in whaanau suffering disproportionately from the impacts of COVID-19 – socially, economically, and in both well-being and health.²⁵⁹

Geoff Milner, the chief executive officer for the Ngaati Hine Health Trust, said that the Ngaati Hine rohe was an unique environment to operate in, considering the majority of whaanau live rurally and experience disproportionately negative outcomes in health, education, housing, and employment.²⁶⁰ These were challenges also articulated by Pita Tipene, who provided evidence in support of the Ngaati Hine claim.

Outside of rural living, Mr Tipene also noted other challenges, including the fact that people are exposed to misinformation and conflicting advice, and have a historic distrust of the Government.²⁶¹ These challenges are compounded by general hardship, where people do not have the ability to buy food or other necessities.²⁶² Despite these challenges, Mr Tipene describes concerted efforts to organise, distribute food parcels and water, and make people feel supported and engaged with. He noted:

the amount of coordination and effort required to carry out this type of work is extensive and costly. A lot of it is done for aroha because this type of work is overlooked and under-prioritised by the Government. That means we have to reach into our own pockets as an iwi and as individuals to support our whanaunga. It is not ideal, but it must be done.²⁶³

Pamela-Anne Ngohe-Simon, who was the co-ordinator for the ‘Super Saturday’ (16 October) vaccination event held in Moerewa, said that the event was easy to run as a result of support from Ngaati Hine Health Trust and others. She noted that the Ngaati Hine Health Trust ‘made sure that funding and resourcing was not an issue’, and that vaccination successes have come from local people getting involved, as opposed to any support received from the Government.²⁶⁴ In her evidence, she highlighted the importance of grass-roots initiatives, like the Ngaati Hine ‘vaccination waka’ which are converted campervans that go out into rural areas delivering the vaccine. Reflecting on how the vaccination waka have been a great outreach tool, Ms Ngohe-Simon affirmed the importance of a kanohi ki te kanohi approach:

258. Document D17, pp 2–3.

259. Ibid, pp 2–3.

260. Document D37, p 1.

261. Document D36, p 7.

262. Ibid, p 8.

263. Ibid.

264. Document D18, p 2.

4.4.5

I think the biggest problem up here now is that what is left over is the hardest group of hard-to-reach people. And to get them to get vaccinated, they are going to need to talk one on one with people they know and trust from within the community. It is no good sending in strangers or nurses even. What we understand is that before you could even talk to them about vaccination, they would need to unload all this raru-raru that they have been holding on to for years about the Government. You might need to spend all day with them listening before you can get to the point that they might agree to be vaccinated.²⁶⁵

Moe Milne, a trustee on the Ngaati Hine Health Trust, drew attention to the Tai Tokerau border patrol efforts, which she described as ‘an example of rangatiratanga in action to protect the iwi’. As far as she is aware, these efforts are most likely operating on whaanau contributions; however, it is these efforts that provide a sense of comfort insofar as knowing that ‘those that pass the border are fully vaccinated’.²⁶⁶

4.4.5 National Hauora Coalition (North Island)

The National Hauora Coalition is the largest Maaori-led primary health organisation in Aotearoa New Zealand. Established in 2011, it currently serves 44,558 whaanau and whaanau Maaori within a total population of 237,932 enrolled service users. Its geographical scope spans three district health board areas, including the Auckland metropolitan area, Waikato, and Whanganui.²⁶⁷

Simon Royal (chief executive) and Tammy Dehar (strategic project leader) presented joint evidence about the impacts of COVID-19. They emphasised that the Crown’s failure to conduct a full and proper impact analysis on the Maaori community had been a fundamental flaw in their approach. They also asserted that Maaori health providers such as the National Hauora Coalition have had to compensate for the Crown’s failings, and throughout the pandemic they have lacked the support required to both fulfil existing commitments and provide advice and guidance to the Crown while under significant time constraints.²⁶⁸ Mr Royal and Ms Dehar also stressed that both the lack of information on the traffic light system and the time given to Maaori providers to give feedback was insufficient, ‘placing an unfair burden on the NHC and other Maaori service providers’ and reflecting a lack of true partnership.²⁶⁹

Since 2020, the National Hauora Coalition have been actively involved with the pandemic response, including assisting with pop-up swabbing clinics, Maaori-led remote care coordination services, and informing the Maaori community.²⁷⁰ Mr

265. Document D18, p 7.

266. Document D16(a), p 9.

267. Submission 4.1.10, p 104.

268. Document D32, p 7.

269. Ibid, pp 12–13.

270. Ibid, p 3.

Royal and Ms Dehar told us that supporting the workforce to increase the number of vaccinators and contact tracers has been a key element of their response.²⁷¹

4.4.6 Te Pou Matakana – Whaanau Ora Commissioning Agency (North Island)

The Whaanau Ora Commissioning Agency has 96 partners throughout the North Island providing health, education, and social services to whaanau. Of those 96 partners, 76 per cent are iwi-owned, have iwi representation on their governance, and/or are affiliated to an iwi. The remaining 24 per cent are owned by urban Maaori organisations. Notably, 81 of the 96 partners have general practice clinics and, overall, the partners have delivered almost 496,000 vaccinations across the network as at 18 October 2021. This means that Whaanau Ora Commissioning Agency and its partners have delivered about 7.8 per cent of all vaccine doses across Aotearoa New Zealand.²⁷² We heard of the work of the Whaanau Ora Commissioning Agency, and its partners, from its chief executive John Tamihere.

Mr Tamihere described how delays in the provision of vaccination data impacted the ability of Whaanau Ora to effectively find and vaccinate Maaori.²⁷³ Mr Tamihere provided the example of the administration of mobile vaccines in Northland alongside Te Tai Tokerau iwi, where vaccinators had to obtain information from bystanders as to the location of unvaccinated Maaori. Coupled with the tight timeframes already in place, Mr Tamihere asserted that the additional time wasted prevented Whaanau Ora providers from engaging with Maaori who were vaccine hesitant.²⁷⁴ Daymon Loy Nin, the chief product and consulting officer at Whaanau Tahī Limited, an information system provider to Whaanau Ora, noted that the experience in Northland indicated that ‘vaccine hesitancy largely disappears when support is offered by trusted people. Whaanau Ora delivered 3,046 vaccinations in Te Tai Tokerau from 8 to 13 November. Between 59 and 83 percent of those were to Maaori.’²⁷⁵

Despite the delay created by lack of data, Whaanau Ora have been working to respond to Maaori needs throughout the pandemic.²⁷⁶ The efforts of Whaanau Ora have been extensive, from setting up testing and vaccination stations across Aotearoa New Zealand, establishing temporary food banks, and facilitating the delivery of kai to those struggling, to taking care of Maaori who have become sick from COVID-19.²⁷⁷

Bradley Norman, the chief executive officer of Whanau Tahī Limited, described the first of three campaigns which took place in October 2021. The campaign was a call campaign aimed at Maaori and Pasifika who needed to rebook their second dose on account of the Trust Arena Vaccination Centre closing. He noted: ‘In the

271. Ibid, p 4.

272. Document D22, p 2.

273. Ibid, p 9.

274. Ibid, p 11.

275. Document D28, p 4.

276. Document D22, p 11.

277. Ibid, pp 11–12.

4.4.7

process, 1,176 calls were made, 606 of which were with Maaori. From those calls, 441 persons were supported to be vaccinated, 232 of whom were Maaori. This indicates a success rate of 38 per cent.²⁷⁸

Overall, the Whaanau Ora Commissioning Agency asserted that it has the ‘capacity, the logistical know-how, and a great reputation of delivering good outcomes for Maaori communities’, with the obstacle to its work being ‘the continual road-blocks’ put in place by ‘Senior Crown officials’.²⁷⁹

4.4.7 Te Koohao Health (Waikato)

Te Koohao Health is a Whaanau Ora service provider, providing whaanau ora services across the wider Waikato region, from Te Kauwhata in the north, to Kaawhia and Tokoroa in the south.²⁸⁰ It has 320 full time and part-time staff, of which 85 per cent are Maaori.²⁸¹ We heard of the work of Te Koohao Health from Lady Tureiti Moxon, who has been its managing director since 2002.

Lady Moxon drew attention to the challenges of self-isolation at home, noting that Te Koohao Health has been referred to 35 households at this stage. While the district health board has offered to pay Te Koohao kaimahi to care for these households, Lady Moxon described that ‘it is not a small job’, and elaborated:

With the resources we have it is untenable to look after 35 households seven days a week (around the clock) given that the homes are small and there are so many people in each household. You really need a dedicated workforce to be able to do this. This would require much more than just being offered a few FTEs from the DHBS and it really needs us to design what is needed and a fund to resource it.²⁸²

Lady Moxon outlined the success of Whaanau Ora, through the work of Te Koohao Health and other sub-contracted organisations and collectives. She noted that Te Koohao has the second highest vaccination rate in the whole of the Waikato region, outside of the mega vaccination clinic at Te Rapa, and has given 26,000 vaccinations.²⁸³ To support vaccination efforts, Te Koohao now has two mobile vaccination vehicles set to operate across the Hamilton and wider Waikato region.²⁸⁴

4.4.8 Te Tihi o Ruahine Whaanau Ora Alliance (MidCentral)

Te Tihi o Ruahine Whaanau Ora Alliance (Te Tihi) is a charitable trust, funded through the Whaanau Ora Commissioning Agency. Te Tihi is comprised of nine members including iwi authorities, Maaori health providers, and Maaori organisations including the Maaori Wardens and Maaori Women’s Welfare League. Te

278. Document D26, p 2.

279. Document D22, pp 17–18.

280. Document D20, p 3.

281. Ibid, p 2.

282. Ibid, pp 14–15.

283. Ibid, pp 4–5.

284. Ibid.

Tihi has provided support, centralised communication, and logistics coordination during lockdowns and all levels of response.²⁸⁵

Di Rump, chief executive of the Maauiupoko Tribal Authority, told us about the challenges they faced as a service provider. Government coordination of services and support in the second lockdown was particularly challenging. Ms Rump explained that whereas in the first lockdown Te Tihi had greater autonomy through direct funding, in the second lockdown the Ministry of Social Development coordinated funding arrangements.²⁸⁶ Responses were particularly slow and it was unclear as to who was responsible for resource management such as delivering food parcels. Ms Rump told us that it felt as though the lessons learnt from the first lockdown about the benefits of giving Maaori providers independence had been lost.²⁸⁷

Ms Rump explained that ‘stepping in to assist the community . . . was not a choice but a cultural imperative driven by whakapapa links and our mana whenua responsibility as tangata whenua.’²⁸⁸ Through collaborating with other Maaori providers, community groups, and iwi, Te Tihi established local and regional response hui, introduced a contact programme to check in with whaanau, provided isolated housing for whaanau experiencing domestic unrest, and produced a televised documentary on their local response.²⁸⁹ Ms Rump also told us that through Te Tihi’s use of tikanga and karakia, they have reached out to vaccine-hesitant people within the community, something which the health department was unable to do.²⁹⁰

4.4.9 Maaori efforts to combat vaccine misinformation

The lag in Maaori vaccination rates precipitated by Cabinet’s rejection of an age adjustment for the rollout also allowed a narrative to take hold that blamed lack of Maaori uptake of the vaccine as the problem, and gave the unsubstantiated impression that Maaori were, on the whole, more anti-vaccination than the rest of the country. In fact, in mid-November, it was established that the number of Paakehaa who were unvaccinated was almost double the number of Maaori who were unvaccinated. Associate Professor Matire Harwood, a South Auckland GP, noted that the narrative that Maaori were the unvaccinated across the nation was not only unfair, but empowered a proportion of people to be bold in their racism.²⁹¹ Dr Bloomfield asserted that, in reality, very few people are actually anti-vaccination, putting the number at ‘less than five percent’ of the total population.²⁹²

285. Document D42, p 1.

286. Ibid, p 6.

287. Ibid, p 7.

288. Ibid, p 6.

289. Ibid, pp 4–5.

290. Ibid, p 8.

291. Maxine Jacobs, ‘Covid-19: More Paakehaa are Unvaccinated but Maaori are being Stigmatised’, Stuff NZ, 6 November 2021, <https://www.stuff.co.nz/pou-tiaki/30047300/covid19-more-pkeh-are-unvaccinated-but-mori-are-being-stigmatised>.

292. Transcript 4.1.10, p 400.

Indeed, it appears that the problem is not that Maaori are anti-vaccination, but that they have been subject to prolonged exposure to misinformation, coupled with other experiences, that has fostered a degree of vaccine hesitancy. The delay in the vaccine rollout to Maaori largely precipitated by Cabinet meant that Maaori communities were subjected to misinformation for a longer period than other population groups.

However, Maaori organisations are combatting misinformation. The New Zealand Maaori Council pinpointed three base causes of vaccine hesitancy:

1. a mistrust of Government/authority/modern science/pharmaceuticals; and/or
2. misinformation from social media platforms (which self-reinforce misinformation with more of the same); and/or
3. 'Lack of bandwidth' – as people have complex, and in some cases, chaotic lives, which means that, in the grand scheme of things, going to 'bookmy vaccine.co.nz' is not a priority or credible choice.²⁹³

In order to protect hesitant whaanau, the New Zealand Maaori Council proposed to coordinate a non-conventional 'anti-disinformation' campaign.²⁹⁴ The New Zealand Maaori Council contacted the Ministry of Health, Te Puni Kookiri (twice), and Te Arawhiti with its proposal to 'out influence the influencers' by flooding social media with hundreds of pro-vaccination messages targeted at Maaori.²⁹⁵ Peter Fraser, the New Zealand Maaori Council's national secretary, noted that despite engagement being unsuccessful as at 31 October 2021, the New Zealand Maaori Council hoped a positive response was pending. However, the council recognised that timeframes were started to become tight and went 'live' with its campaign on 31 October 2021 using its own funds, with the expectation that the Crown funding might 'catch up'. At the time this priority inquiry commenced, this proposal was still sitting with Te Puni Kookiri.²⁹⁶ This is an example of Maaori addressing the misinformation that leads to vaccine hesitancy head on and it was not the only example of such work provided to us throughout the course of the inquiry.

Lady Tureiti Moxon noted that when providers are able to reach Maaori and talk to them *kanohi ki te kanohi*, they are often able to overcome concerns about vaccination.²⁹⁷ This was also a feature of Eleanor Hamlin-Paenga's evidence:

Last week, we sent a nurse to vaccinate four members of a household of seven. kws kaimahi have worked with this household on a number of occasions. The nurse sat with the household members and listened to and responded to their concerns. All seven members of the household then chose to be vaccinated.

On another occasion, one of our Fijian-Indian nurses was running a vaccination

293. Document D9(a), p 15.

294. Ibid, p 18.

295. Document D9, pp 6–7; doc d9(a), pp 18–19.

296. Document D9, p 7.

297. Document D20, p 9.

clinic and was approached by a middle-aged Maaori woman whose stance was entirely mana motuhake, anti-vaccination. This woman had her mokopuna with her. After twenty minutes of conversation, this woman decided to be vaccinated herself, and called her entire family down to also be vaccinated.²⁹⁸

Robert Gabel, providing evidence on behalf of Ngaati Tara, described his experience with misinformation: 'I recall early on there was conversation around the vaccination being linked to 5G. There are also concerns around the composition of the vaccine and its link to aborted foetal cells, as well as concerns about possible adverse effects including death.'²⁹⁹

Mr Gabel noted that the Crown had not addressed the misinformation that was out there and he placed the onus on the Crown to do so, stating:

it would be helpful for the government to have addressed these concerns head on through educating people about the vaccine, what the mRNA vaccine is, its composition and how it works. At this stage nobody knows whether the vaccine is absolutely safe, and many have concerns. But it is at the very least a stopgap measure.³⁰⁰

The susceptibility of Maaori to misinformation was linked to Maaori distrust in government, borne from a history where they have been prejudiced. Kara George, providing evidence on behalf of Te Kapotai and Ngaati Pare, articulated an 'undercurrent of mistrust of the Government' that runs through Te Kapotai. He stated:

I think too that we have become so accustomed to the fact that we are going to be the last group targeted for assistance, we are going to be at the back of the queue. We have become so inured to being virtually ignored by the Government when it comes to social and health issues – we are hardened to it, desensitised by it. It has got so bad that when a crisis happens, we do not even look to the Government anymore, we know the drill, we know we are going to have to figure things out for ourselves and devise our own community-led solutions based on what we know works.³⁰¹

Mistrust is compounded by racism as a social force. Indeed, racism is a key factor relevant to the social determinants of health and, as Dr Bloomfield told us in our stage one inquiry, is associated with poorer health outcomes.³⁰²

4.4.10 Koorero whakatepe

In this pandemic, Maaori health and social service providers have, as one would expect, taken responsibility for caring for communities with some of the most complex health needs across Aotearoa New Zealand. They have done so despite

298. Document D27, p 4.

299. Document D19, pp 5–6.

300. Ibid, p 6.

301. Document D1, para 6.

302. Waitangi Tribunal, *Hauora*, p 21.

inadequate and delayed Government support, which as we said in an earlier section, was in breach of the Treaty.

As acknowledged by Crown counsel, the Government was working with a system that ‘was not designed to work at this speed, structurally or in terms of people capacity.’³⁰³ Additionally, the health system is also in breach of the Treaty. We emphasised in *Hauora*, and Crown witnesses agreed in that inquiry, that the Maaori primary care system is broadly, in terms of its successes in addressing inequity, a benchmark for the rest of the primary health sector.³⁰⁴

The Crown did not need to wholly rely on its own system. There was an entire network of Maaori health providers and Whaanau Ora providers ready and waiting for adequate support, with the expertise and commitment to do arguably the hardest work of the vaccine rollout – vaccinating Maaori communities. All the Government needed to do was support those providers by introducing a truly equitable vaccine rollout to facilitate their efforts in their communities. All it needed to do was engage with Maaori health experts and professionals, and collaborate meaningfully on equity-enhancing programmes, and get resourcing and funding to them as quickly as it could muster.

Cabinet failed to introduce an equitable vaccine rollout, and put Maaori providers on the back foot as a result. Government agencies’ attempts to facilitate Maaori providers in their attempts to play catch-up are inadequate and much too late.

The increased risk to Maaori that the Government has been trying, desperately, to mitigate since October with additional payments and support, was created in large part due to the Government’s own poor policy decisions.

We emphasise: the deficit-oriented language that Maaori are a vulnerable group ignores the fact that it was Cabinet, through its early poor decision-making on the age-based vaccine rollout, that made Maaori less protected against COVID-19, and Delta in particular. The vulnerability was created and is sustained by a policy problem, not a problem with those communities.

Because even the relatively positive measures to try to prioritise delivering the vaccine where it is most needed were not enough to make up for the inequities experienced by Maaori communities, Cabinet has effectively taken a broad policy approach as if Aotearoa New Zealand is a homogenous population. The result of this approach is that the Maaori population is now in an even more vulnerable position relative to the general population. This was avoidable.

We are reminded of the definition of institutional racism that claimant witnesses in stage one evidence provided: ‘a *pattern* of differential access to material resources, cultural capital, social legitimation and political power that disadvantages one group, while advantaging another’ (emphasis in original).³⁰⁵

303. Submission 3.3.58, p 4.

304. Waitangi Tribunal, *Hauora*, p 156.

305. Document A57, p 5; Waitangi Tribunal, *Hauora*, p 21.

4.5 THE POSSIBILITY OF AN ADVERSE PUBLIC REACTION

In a letter to the New Zealand Maaori Council, dated 16 November 2021, Prime Minister Jacinda Ardern expressed that the Government was hesitant to set particular vaccination targets for Maaori before moving to the Protection Framework because it would risk ‘creating a perception amongst some, that that group is preventing the country from opening up more quickly’.³⁰⁶

We suspect that similar concerns informed Cabinet’s decision to reject an age adjustment for Maaori in the initial vaccine rollout. Given there was a clear public health rationale for the prioritisation of Maaori in the vaccine rollout, fear of a racist backlash against Maaori is not a good enough justification for failing to take all reasonable measures to ensure equity. Notably, Dr Bloomfield stated that the Ministry of Health had anticipated the potential for racism to play a role in the public response as the outbreak unfolded.³⁰⁷ As discussed in the previous section, we observe that the Crown bears some responsibility for the misinformation and vaccine hesitancy present in Maaori communities now, and the fact that some members of the public see these factors as primarily a problem with those communities rather than a problem with how slow the vaccine rollout has been for Maaori. The delay in the vaccine rollout and the creation of this inequity could have been avoided.

More fundamentally, what is often misunderstood is that the prioritisation of Maaori and other at-risk population groups does not equate to those groups being more important, or getting ‘more’, than others. The focus of the prioritisation is not Maaori themselves, but rather a proportionate recognition that the inequitable outcomes they suffer from require more attention and resources to resolve.

Healthcare provides useful analogies for undoing this misunderstanding. Adhering to public health principles does not indicate that some *people* are inherently more important than others or unfairly receive ‘more’, but rather that the *injuries they suffer from* require different types, and levels, of care. Someone with a traumatic brain injury receiving expensive and intensive surgery does not mean that that person is more important than another person with a broken arm *not* receiving that same treatment; the difference is that one person’s need is greater than the other, and requires more care. While there might be a ‘disparity’ in the level of care provided, that disparity is not ‘unfair’ – the disparity is needed in order to restore the health and well-being of each person to the same level.

While comparable to the above analogy, the marked differences in health outcomes for Maaori compared with other population groups are due to a variety of very complex, and compounding, factors. Again, these factors are not about an inherent vulnerability in the Maaori population – they are representative of the fact that Maaori, as a population group, disproportionately experience other negative social determinants of health. Many of those factors are a result of differential

306. Document D9(a), p 12.

307. Transcript 4.1.10, p 400.

access to power and resources, some across several generations. In stage one, the Crown acknowledged:

the disparities that exist for Maaori in primary health are influenced by the cumulative effects of colonisation, as well as the broader social determinants of health (which include household crowding, material hardship and education), and other contributory factors (including environmental factors).³⁰⁸

Crown counsel accordingly said we need not inquire into the extent to which there were links between colonisation and the poorer health outcomes experienced by Maaori today.³⁰⁹ This was an important acknowledgement that the Crown's own historical policy failures, both distant and recent, now play out in the present as a series of inequities experienced by Maaori communities.

The Ministry of Health's definition of equity is:

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.³¹⁰

In stage one, Crown officials essentially told us that to properly account for the complex and acute compounding of inequitable social, economic, and cultural impacts on Maaori, they cannot simply be captured by targeting each of those factors without accounting for ethnicity. Because Maaori experience all of those factors at a much higher rate than other population groups, a key way to address those inequities is to factor ethnicity in as an explicit indicator of poor health. That is, for example, reflected – albeit insufficiently – in the way the Crown funds primary care services: there are factors that provide more money to providers with high proportions of Maaori patients, because their health needs are more likely to be more complex.³¹¹

The age adjustment for the vaccine rollout, and the option to delay the transition to the Protection Framework, were opportunities for the Crown to take pro-equity steps to address the disparity in need and the associated health outcomes for Maaori. Instead, the Crown made inequitable decisions that put Maaori as a population group at a clear disadvantage compared to other population groups, at least in part because of a concern about a backlash against Maaori.

Earlier in the chapter, we quoted Minister Hipkins:

308. Submission 3.1.155, p 3.

309. Ibid; Waitangi Tribunal, *Hauora*, pp 20–21.

310. 'Achieving Equity', Ministry of Health, <https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity>, last modified 1 October 2019.

311. Waitangi Tribunal, *Hauora*, pp 99–101; 103–107.

If unvaccinated Maaori were willing to be vaccinated but unable to access vaccines because of existing inequities in the health system, or owing to a range of socio-economic factors such as access to transport, then the Crown would accept there may be an inequitable risk of getting COVID and having worse outcomes. It is too soon to assess this matter as the vaccination effort continues.³¹²

Minister Hipkins would not directly accept that Maaori were put at inequitable risk by the way the vaccination rollout was managed. In answers to written questions, the Minister said:

Although Cabinet was aware the change would put vulnerable Maaori at greater risk, it is important to note that it is not Maaori as a whole who are at risk: it is vulnerable Maaori, who, just like the vulnerable in all communities, are always at the greatest risk of adverse outcomes. When it comes to COVID – health equity is about preventing as far as possible those vulnerable to the disease from catching it and if they do from the worst effects.³¹³

We note that Minister Hipkins's understanding of inequities between population groups, and the best way to address those inequities, does not accord with the Ministry's own definition of equity or its efforts to achieve it, which include specifically factoring in ethnicity as an indicator of poorer health outcomes and increased vulnerability.

When the Crown announces equitable policy that uplifts Maaori and addresses their needs, including their Treaty rights and guarantees, we accept that there is often a backlash. The burden of that backlash falls primarily on Maaori communities, and to some extent we recognise the Crown's caution. But the age adjustment, and more broadly the need to expressly prioritise Maaori in the vaccine rollout, was universally endorsed by public health professionals, including the Crown's own senior officials. The Crown could have easily justified it on the basis that it was science. The age adjustment was intended as perhaps the best proxy to solve an inherent, indisputable, mathematical disadvantage posed to the Maaori population. The Crown instead formulated a different, less equitable path in its vaccine rollout. The rapid move to the Protection Framework followed this path.

The Crown should be defending the Treaty partnership, and the equitable treatment of Maaori. The clear risk of failing to do so is that existing inequities remain, or worse still, are exacerbated.

The reality is that the inequitable vaccine rollout has exacerbated Maaori health inequities. The Delta outbreak that began in August 2021 has, to date, disproportionately infected, hospitalised, and killed Maaori. We are yet to see whether these numbers will improve or worsen with the transition to the Protection Framework,

312. Document D32(a), p 5.

313. Ibid.

but the Ministry of Health's own advice to Cabinet was that Maaori would again be disproportionately affected by the transition.

The Crown has a Treaty duty to adopt rational, scientific, equitable policy choices for Maaori. It has a moral and ethical duty to defend them against unreasonable public backlash. It cannot simply find ways of avoiding these duties by coming up with less equitable alternatives; it *must* make those choices that sustain Maaori well-being, and then explain and defend them as long and as vocally as is required. Failing to perform these duties for the sake of political convenience does not reflect the Treaty partnership and, in fact, threatens the fundamental basis for it.

The Government's failure to discharge these duties in respect of its vaccine roll-out, and in choosing to rapidly shift to the Protection Framework, has prejudiced Maaori, and is itself a grave breach of the Treaty.

4.6 PREJUDICE

We find the claim before us to be well-founded. Both the immediate and lasting prejudice arising from the Treaty breaches we have found cannot be understated. It is profound, and also impossible to accurately account for.

In effect, the lack of adequate protection for Maaori afforded by the move to the COVID-19 Protection Framework *is* the prejudice that has resulted from Cabinet's earlier decision to reject an age-adjusted vaccine rollout.

Had this lag not been built into the vaccine rollout from the beginning, and had more active policy and actions been implemented to lift Maaori vaccination rates early in the rollout, then a rapid shift to the Protection Framework might have been possible without putting Maaori at disproportionate risk.

As we have found, the Crown bears significant responsibility for the current disproportionately lower vaccination rate for Maaori. In turn, the Delta outbreak that began in August 2021 has, to date, disproportionately infected, hospitalised, and killed Maaori. On Monday 13 December 2021, researcher Dr Rawiri Taonui reported:

- ▶ 37 of the 101 new cases that day were Maaori, the biggest proportion by population group of new cases that day; and
- ▶ no Paakehaa community cases had been recorded for two consecutive days.

He also recorded the broader impacts of the Delta outbreak on Maaori. As at 13 December:

- ▶ of a total 8,814 Delta cases, 4,464 have been Maaori (50.6 per cent), more than any other population group. For the first time, Maaori comprised over 50 per cent of cases;
- ▶ Maaori comprised the highest number of new cases for 9 out of the preceding 11 days;
- ▶ Maaori comprised either the highest or the second-highest number of new cases for 80 consecutive days;
- ▶ of a total 495 hospitalisations, 191 Maaori have been hospitalised (38.6 per cent), more than any other population group; and

- ▶ of a total 20 deaths, 9 Maaori have died (45 per cent), more than any other population group.³¹⁴

What these numbers reveal is not only that Maaori are more likely to get infected. They also show that Maaori, once infected, are more likely to get hospitalised and more likely to die, because of the inequities and social determinants of health which Maaori (as a population group) already disproportionately experience. This points to the far-reaching and complex nature of the prejudice Maaori experience as a result of the inequitable vaccination rate.

Aotearoa New Zealand's overall statistics, and even the specific hospitalisation and mortality numbers for Maaori, may compare favourably with other countries, as Dr Ashley Bloomfield acknowledged. However, infection, hospitalisation, and death have enormous direct impacts on individual whaanau and on tight-knit, contiguous Maaori communities.³¹⁵ More importantly from a Treaty and equity perspective, international comparisons mean little.

Indeed, many of these contiguous Maaori communities with lower vaccination rates are in areas likely to see a huge influx of holidaymakers from Auckland over summer, such as Northland, Waikato, Gisborne, and the Bay of Plenty.³¹⁶ Modelling provided to the Crown on 9 November to inform its decision-making about the move to the Protection Framework, and which the Crown presented as evidence in our inquiry, suggested as many as 100,000 Aucklanders could be leaving the city per week over the holiday period.³¹⁷

A second assessment on 15 November, also provided by the Crown as evidence, modelled the risk posed to populations in different geographic areas. It did so by assessing the vaccination rate for each area against the 'higher health vulnerability' of the populations in those areas. The assessment concluded that the five areas with the highest health vulnerability scores and the lowest vaccination coverage are: Whanganui (26.2 per cent Maaori);³¹⁸ Wairoa (65.7 per cent Maaori);³¹⁹ South Waikato (35.3 per cent Maaori);³²⁰ Hauraki (22.9 per cent Maaori);³²¹ and Kawerau (61.7 per cent Maaori).³²²

314. Dr Rawiri Taonui, 'Zero Paakehaa Cases – Maaori and Pacific Set New Delta Records', Waatea News, 13 December 2021, <https://waateanews.com/2021/12/13/dr-rawiri-taonui-zero-pakeha-cases-maori-and-pacific-set-new-delta-records>. Dr Taonui cites Ministry of Health data as his sources.

315. Transcript 4.1.10, p 423.

316. Document D49(a), p 5.

317. *Ibid*, p 3.

318. 'Whanganui District', Statistics New Zealand, <https://www.stats.govt.nz/tools/2018-census-place-summaries/whanganui-district>, accessed 15 December 2021.

319. 'Wairoa District', Statistics New Zealand, <https://www.stats.govt.nz/tools/2018-census-place-summaries/wairoa-district>, accessed 15 December 2021.

320. 'South Waikato District', Statistics New Zealand, <https://www.stats.govt.nz/tools/2018-census-place-summaries/south-waikato-district>, accessed 15 December 2021.

321. 'Hauraki District', Statistics New Zealand, <https://www.stats.govt.nz/tools/2018-census-place-summaries/hauraki-district>, accessed 15 December 2021.

322. Document D49(a), pp 6–7.

As can be seen, when compared to the Statistics New Zealand 2018 Census results, all these districts have higher Maaori populations than the national average.

The 15 November assessment also noted:

Outside of towns and cities, although vaccination coverage is poor . . . it does not typically coincide with high health vulnerability. An exception to this pattern is Tairāwhiti and Northland, which both have high health vulnerability combined with low vaccination coverage – both frequently being in the top (riskiest) tertile.³²³

The populations in Northland and Tairāwhiti (Gisborne) are 36 per cent and 52 per cent Maaori respectively.

Importantly, the assessment's authors used Ministry of Health vaccination data to complete their analysis, and noted that this data undercounts 'certain groups'. As Crown, claimant, and interested-party witnesses all confirmed in our inquiry, that includes a significant undercount for Maaori, particularly in Northland.³²⁴ Therefore the number of unvaccinated Maaori at risk from the Auckland border opening is likely to be higher than the already troubling modelling indicates.

Moreover, we note that the likely prejudice to Maaori as a result of what is commonly referred to as 'long COVID' cannot be accurately predicted. Clearly, the already inequitable Maaori mortality rate is likely to be negatively affected, in part because of the disproportionate number of deaths, but also because of reduced long-term quality of life.

323. Document D49(a), p7.

324. Ibid, p6.

CHAPTER 5

RECOMMENDATIONS

We set out our overall recommendations to remedy the present and likely prejudice suffered by Maaori as a result of the Crown's Treaty breaches. We include several further, more detailed recommendations to provide more direction to the Crown on how it should fulfil its obligations. We were assisted by the recommendations sought by the parties in making our recommendations.

At the outset, we suspect the most impactful remedy for this prejudice may have been to maintain the border around Auckland until vaccination rates are high enough to provide Maaori communities an equitable level of protection from a Delta outbreak. We cannot make that recommendation because the border was lifted at 11:59pm on 14 December 2021.

Instead, our recommendations focus on other elements of the Crown's pandemic response, including for the future rollout of the paediatric vaccine and the booster vaccine. In doing so, we emphasise that none of these should be considered 'mitigations' to justify the more rapid move to the Protection Framework. All are necessary to avoid the prejudice associated with that move.

The Crown's Treaty breaches have contributed significantly to the disproportionately lower levels of vaccination in Maaori communities. Because the Crown has failed to equitably vaccinate Maaori, the Protection Framework will not actively protect Maaori until Maaori vaccination rates are comparable to the general public. The Crown must pursue *all* these recommendations, as active protection dictates, *to the fullest extent practicable* and *as matters of extreme urgency*. The Crown will remain in active Treaty breach until it ensures an equitable vaccine rollout, which protects the Maaori population equitably.

5.1 FURTHER FUNDING, RESOURCING, DATA, AND OTHER SUPPORT TO MAAORI SERVICE PROVIDERS AND COMMUNITIES TO SUPPORT THEIR PANDEMIC RESPONSE

Crown counsel acknowledged it was clear from the hearing and evidence that 'Maaori want and need more . . . funding and resourcing' to assist with their pandemic response.¹ It was clear to us that Maaori also want and need all of these things much quicker than the Crown has provided them to date if they are to achieve equity for their communities.

1. Submission 3.3-58, p 3.

We also heard evidence, particularly from those parties involved in the recent High Court and Court of Appeal proceedings between the Whaanau Ora Commissioning Agency and the Ministry of Health, that data on unvaccinated Maaori that was critical to the vaccination effort was not easily forthcoming. As the matters before other courts were ruled out of scope and those proceedings are over, we make no specific comment about that particular issue.

The general point about the provision of data made by parties in this inquiry, however, makes sense to us. The Treaty standard is that if Maaori health providers and whaanau ora providers are to be effective, the Crown must adequately resource them to carry out their job. This includes, where practicable, providing them with data that would assist them with their efforts.

Based on the evidence provided, we recommend that further funding, resourcing, data, and other support should be urgently provided to assist Maaori service providers and communities with:

- ▶ the continuing, urgent vaccination effort – including for the paediatric vaccine and booster vaccine – especially in rural areas and in communities living in areas with lower socio-economic decile ratings.
- ▶ targeted support for whaanau hauaa and taangata whaikaha.
- ▶ testing and contact tracing.
- ▶ caring for Maaori with COVID-19.
- ▶ self-isolation and managed isolation programmes.

5.2 COLLECTION OF AND REPORTING ON DATA RELATING TO ETHNICITY AND ON PEOPLE WITH DISABILITIES

Although we heard that data was not always forthcoming for Maaori involved in the pandemic response, we also heard evidence that the data collected by the Crown does not accurately or effectively capture information for particular population groups, including Maaori.² In particular, we are concerned that the undercounting of Maaori means that the officially recorded inequitable gap in vaccination rates may be an underestimate.³

We therefore reiterate our recommendation in *Hauora*⁴ with greater urgency: the Crown should improve its collection of quantitative and qualitative ethnicity data and information relevant to Maaori health outcomes. This data and information should be made public and be easily understandable and accessible, subject to relevant legislation.

We note the practical absence of quality data on taangata whaikaha and whaanau hauaa. Joanne Gibbs told us that the available data is ‘only able to identify approximately 40,000 out of an estimated 1.1 million disabled people (or 600,000 people

2. This was also a message in stage one in relation to primary care data: Waitangi Tribunal, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Lower Hutt: Legislation Direct, 2019), pp 129–133.

3. Document D12, pp 13–14; doc d3, p 3.

4. Waitangi Tribunal, *Hauora*, p 168.

between ages of 16–64), and this in turn has made it very difficult to track vaccine uptake for those groups.⁵ This will have implications for the paediatric vaccine and booster vaccine rollout.

We were told work to improve this is already underway, in conjunction with non-governmental organisations, community groups, and district health boards.⁶

We recommend that the Crown prioritise the work to improve the quality of quantitative and qualitative data on taangata whaikaha and whaanau hauaa in partnership with Maaori disability care providers and community groups. This data and information should be made public and be easily understandable and accessible, subject to relevant legislation.

5.3 MONITOR THE PANDEMIC RESPONSE TO ENSURE ACCOUNTABILITY TO MAAORI

It is critical that the Crown's pandemic response is monitored to assess in real time whether its Maaori-specific policies are effective, and to assess the Crown's overall pandemic response as it affects Maaori. It is also critical that this monitoring is designed and carried out in partnership with Maaori. In *Hauora*, we stated:

It is not solely for the Crown to determine what will be measured and how it will be reported. We emphasise that the Crown cannot be the sole auditor of its own performance – the Treaty obliges Crown agents to ensure that the health system is accountable to their Treaty partner.⁷

Although we have concerns about the quality of the data available to the Crown to monitor its health response for Maaori, we consider there is sufficient data available to the Crown to be able to identify early whether or not its policies are having the desired effect. For example, the Crown is able to identify in close to real time the number of vaccines administered and the percentage of the population, both general and Maaori, that have received their first and second vaccine doses. This should have identified early that the vaccination strategy was not working for Maaori and enabled the Crown to change the settings or pivot earlier to achieve greater vaccination rates for Maaori. It is not clear from the evidence before us that the Crown properly monitored the vaccine rollout in real time to identify and address this issue before it became a problem.

We also heard from Te Puni Kookiri that it is now actively involved in the vaccine rollout, as it administers the Maaori Communities COVID-19 Fund jointly with Te Arawhiti and the Ministry of Health. In response to questioning regarding who is monitoring the Crown's performance for Maaori in its pandemic response, Grace Smit advised that it would be inappropriate for Te Puni Kookiri to now

5. Document D48, p 33.

6. Ibid p 33.

7. Waitangi Tribunal, *Hauora*, p 133.

monitor its own performance. The Crown indicated to us that its response is monitored by the Maaori Monitoring Group, although very little evidence was presented to us about how that group operates and the monitoring role it plays. As a result, it is not clear to us who is monitoring the Crown's response to the pandemic as it relates to Maaori.

We recommend that:

- ▶ the Crown strengthen its monitoring regime to enable it to identify, in as close to real time as possible, whether or not its policy settings in relation to Maaori are working as expected, so as to enable the Crown to change those settings to achieve the desired and intended results, and remain accountable to its Treaty partner.
- ▶ the Crown partner with Maaori to determine what elements of the pandemic response should be monitored and how that monitoring should be reported.

5.4 ENSURE THE PAEDIATRIC VACCINE AND BOOSTER VACCINE ROLLOUT IS EQUITABLE

The Crown must, while urgently correcting its inequitable vaccine rollout for Maaori adults, also begin to plan for the paediatric vaccine rollout and the booster vaccine rollout. We heard from witnesses, including public health experts, who stressed that this next phase of the vaccine rollout was critical to get right. Dr Danny de Lore and his colleagues painted a grim picture of the likely impact of a Delta outbreak on Maaori children, and Associate Professor Siouxsie Wiles warned us that the Omicron variant could pose even greater risk.⁸ We heard further evidence that Maaori are concerned that the same inequity that was built into the initial vaccine rollout will also become a feature of the booster vaccine rollout.

We recommend that the Crown partner with Maaori to design and implement an equitable paediatric and booster vaccine sequencing framework for Maaori, incorporating the expert advice offered in this inquiry.

5.5 EMPOWER MAAORI TO COORDINATE THE MAAORI PANDEMIC RESPONSE

In answers to our questioning on the last day of the hearing, Crown counsel summarised the key tension revealed in this pandemic response: that, in our constitutional system, while Crown agencies might give contestable advice and Maaori and other groups wield important influence, Cabinet ultimately makes the decisions.⁹

If Cabinet, in our constitutional system, makes the decisions, how can tino rangatiratanga afford joint decision-making for Maaori?

In *Hauora*, we noted the importance of what is sometimes referred to as the 'two spheres' of the Treaty relationship. As highlighted by *Ko Aotearoa Teenei*,

8. Document D8(a), pp 8–11; transcript 4.1.10, pp 41–42.

9. Transcript 4.1.10, pp 41–42.

‘increasingly, in the twenty-first century, the Crown is also Maaori.’¹⁰ The fact that kaawanatanga agencies and institutions, including Cabinet itself, has a strong Maaori presence is an important reason why the Treaty relationship is, to some degree, improving. However, we underline that Maaori representation in Parliament and in Cabinet is not itself a manifestation of tino rangatiratanga, but of the article 3 guarantee of citizenship rights.

In this way, the fact that ‘increasingly, the Crown is also Maaori’ does not fulfil the Treaty partnership. Only the proper recognition and respect of tino rangatiratanga – as manifested through iwi, hapuu, and other Maaori collectives – can reflect the Treaty partnership. Again, we quoted *Ko Aotearoa Teenei* to this effect in our stage one report:

On the Crown’s part there must be a willingness to share a substantial measure of responsibility and control with its Treaty partner. In essence, the Crown must share enough control so that Maaori own the vision, while at the same time ensuring its own logistical and financial support, and also research expertise, remain central to the effort.¹¹

This standard has not been met in the Crown’s response to this health crisis, in large part due to Cabinet decision-making leading to inequitable outcomes. Even though Maaori Ministers were advocating for the interests and needs of Maaori at a key point in the shift to the Protection Framework, the Cabinet process scuttled that effort. The partnership standard expressed in *Ko Aotearoa Teenei* has also not been met in the Crown’s overall attempt to coordinate and facilitate the Maaori pandemic response.

We repeat what we said in chapter 3: the expansive kaawanatanga powers exercised in this emergency and the need for agile decision-making by the Executive means the Crown’s obligation to actively protect tino rangatiratanga and partner with Maaori is intensified.

The most pressing need in fulfilling the Crown’s obligation to empower Maaori in the pandemic response – as broadly called for by all parties – is to fund and resource Maaori providers and iwi groups. But we are mindful that if Crown decision-making continues to result in inequitable outcomes for Maaori, that this funding and resourcing may not be enough. The contestable advice and advocacy through usual channels may not be enough to remedy the prejudice Maaori are experiencing and are at risk of experiencing if the paediatric and booster vaccine rollout is similarly inequitable.

We are optimistic that the Maaori Health Authority, as a key Crown agency that will ideally act as an agent for tino rangatiratanga in respect of health, will go some

10. Waitangi Tribunal, *Ko Aotearoa Teenei: A Report into Claims concerning New Zealand Law and Policy Affecting Maaori Culture and Identity, Te Taumata Tuarua*, 2 vols (Wellington: Legislation Direct, 2011), vol 2, p 451; Waitangi Tribunal, *Hauora*, p 92.

11. Waitangi Tribunal, *Ko Aotearoa Teenei: A Report into Claims concerning New Zealand Law and Policy Affecting Maaori Culture and Identity, Te Taumata Tuatahi* (Wellington: Legislation Direct, 2011), pp 161–162; Waitangi Tribunal, *Hauora*, p 92.

way to actively protecting Maaori going forward. But it is not up and running yet, and further, it is a Crown entity. We see it as imperative that Cabinet, and the Crown more broadly, are more directly held to account to persuade it to not make policy to appease the general public at the expense of equity and fairness. It needs some encouragement to front-foot and defend equitable policy.

We see merit, therefore, in engagement processes that empower Maaori, collectively, to speak directly to Cabinet on those issues, and to make sure Cabinet is clear, straight from its Treaty partners, on what is needed, and when.

In making this observation, we are aware that the parties were somewhat split on what empowering Maaori to coordinate the pandemic response would look like. Some parties favoured a national body or collective to help coordinate the Maaori voice to Cabinet. The claimants and the Crown, throughout hearings, told us that such a group was in the process of being set up, and that it would include not just key Maaori groups and iwi but also Ministers of the Crown.

Others were sceptical that this would become another layer of bureaucracy that they could not afford to navigate in the middle of an emergency. We share these concerns. While we see merit in a national collective, we would not like to see the Crown engage with it at the expense of equally robust engagement with iwi, hapuu, or other Maaori organisations.

It is not for us to tell the Treaty partners how to engage for this pandemic. It is for the Crown and Maaori to decide, in light of the Treaty principles we have discussed. Having made that observation, the parties, including the Crown, encouraged us to make recommendations that might inform future engagement between the Crown and Maaori. Accordingly, we recommend that future engagement between Maaori and the Crown, with the national collective proposed by the claimants *and* with other Maaori groups, should reflect the following principles:

- ▶ it must give effect to tino rangatiratanga in its constitution and decision-making processes;
- ▶ it must be broadly representative of Maaori iwi, providers, and other national groups including but not limited to all of the interested parties who participated in this priority inquiry;
- ▶ similarly, it must have access to a broad range of expertise, including from Maaori health, whaanau ora, and disability service providers;
- ▶ it must meet regularly;
- ▶ Maaori must influence the agenda;
- ▶ key Ministers should be actively engaged, which at a minimum should include the COVID-19 Response Minister, the Minister and Associate Ministers of Health, the Minister for Social Development, the Minister for Maaori-Crown Relations, and the Minister for Maaori Development;
- ▶ key Crown officials should be actively engaged, which at a minimum should include the chief executives or other senior officials from the COVID-19 All-of-Government Response Group, the Ministry of Health, the Ministry for Social Development, Te Arawhiti, and Te Puni Kookiri; and
- ▶ any pending Cabinet papers that materially impact on the Maaori pandemic response should be tabled, and discussed.

Dated at Wellington this 20th day of December 2021



Judge Damian Stone, presiding officer



Associate Professor Tom Roa, member



Tania Te Rangingangana Simpson, member



Professor Linda Smith, member



APPENDIX I

A TIMELINE OF KEY CROWN DECISIONS IN THE PANDEMIC RESPONSE

EARLY OUTBREAK

- 28 February 2020: First COVID-19 case reported in Aotearoa New Zealand.
- 14 March 2020: The Government announces anyone entering the country must self-isolate for 14 days (except for those arriving from the Pacific).
- 19 March 2020: All indoor gatherings of more than 100 people are to be cancelled. The borders close to everyone except for citizens and residents.
- 21 March 2020: The Government introduces a four-tiered Alert Level system and Aotearoa New Zealand is announced to be at Alert Level 2.
- 23 March 2020: The country moves to Alert Level 3 at 1:30 pm.

FIRST NATIONWIDE LOCKDOWN

- 25 March 2020: The country moves to Alert Level 4 at 11:59 pm. A State of National Emergency is declared at 12:21 pm.
- 31 March 2020: The State of National Emergency is extended. It will be extended a further six times between April and May 2020.
- 9 April 2020: The Director-General of Health issues an order requiring all people entering New Zealand by air to enter managed isolation and quarantine.
- 16 April 2020: The Ministry of Health publishes the *Initial COVID-19 Maaori Response Action Plan*.
- 27 April 2020: Aotearoa New Zealand moves to Alert Level 3 at 11:59 pm.
- 13 May 2020: The country moves to Alert Level 2 at 11:59 pm. The State of National Emergency expires at 12:21 pm.

FIRST NATIONWIDE LOCKDOWN ENDS

- 8 June 2020: The country moves to Alert Level 1 at 11:59 pm.
- 9 July 2020: The Ministry of Health publishes the *Updated COVID-19 Maaori Response Action Plan*.

FIRST AUCKLAND LOCKDOWN BEGINS

- 12 August 2020: The Auckland region moves to Alert Level 3 at 12 noon and the rest of Aotearoa New Zealand moves to Alert Level 2 after four COVID-19 cases are recorded in the community on 11 August.

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30 August 2020: Auckland moves to Alert Level 2 at 11:59 pm, with extra restrictions on travel and gatherings. The rest of Aotearoa New Zealand remains at Alert Level 2.

September 2020: Weekly testing for MIQ staff in quarantine facilities and fortnightly for those in managed isolation facilities is instituted.

21 September 2020: All regions outside of Auckland move to Alert Level 1 at 11:59 pm.

23 September 2020: Additional restrictions on travel and gatherings are removed for Auckland at Alert Level 2.

5 October 2020: The managed isolation allocation system goes live. From 3 November 2020, travellers are legally required to have an MIQ voucher before flying if they are arriving in New Zealand.

FIRST AUCKLAND LOCKDOWN ENDS

7 October 2020: Auckland moves to Alert Level 1 at 11:59 pm.

12 October 2020: The New Zealand Government signs an agreement with Pfizer to buy 1.5 million doses of the Pfizer–BioNTech COVID-19 vaccine.

7 December 2020: Cabinet approves the proposed sequencing framework in principle (subject to updating to reflect new and emerging evidence).

9 February 2021: Cabinet notes the Pfizer COVID-19 vaccine has been granted provisional consent by Medsafe and is available for use in Aotearoa New Zealand.

SECOND AUCKLAND LOCKDOWN BEGINS

14 February 2021: Auckland moves to Alert Level 3 at 11:59 pm after three COVID-19 community cases are recorded. The rest of the country moves to Alert Level 2.

17 February 2021: Auckland moves to Alert Level 2 at 11:59 pm. The rest of the country moves to Alert Level 1.

VACCINE ROLLOUT BEGINS

19 February 2021: The first COVID-19 vaccinations are administered.

SECOND AUCKLAND LOCKDOWN ENDS

22 February 2021: Auckland moves to Alert Level 1 at 11:59 pm.

THIRD AUCKLAND LOCKDOWN BEGINS

28 February 2021: Auckland moves to Alert Level 3 at 6 am. The rest of the country moves to Alert Level 2.

7 March 2021: Auckland moves to Alert Level 2 at 6 am. The rest of the country moves to Alert Level 1.

- 8 *March 2021*: Cabinet agrees to an allocation of 40,000 courses of vaccine to Maaori and Pacific providers to distribute to older people living in whaanau environments (and their households) in hard-to-reach places. Cabinet noted that the Ministry of Health will partner with Maaori and Pacific providers to deliver vaccinations in their communities, and they will be provided with ongoing vaccine allocations from Tier 2(b) onwards.
- 10 *March 2021*: COVID-19 Response Minister Chris Hipkins announces the COVID-19 rollout plan using the Pfizer–BioNTech COVID-19 vaccine with four vaccine rollout groups.

THIRD AUCKLAND LOCKDOWN ENDS

- 12 *March 2021*: Auckland moves to Alert Level 1 at midday.
- 26 *March 2021*: Ministry of Health publishes the *COVID-19 Maaori Vaccine and Immunisation Plan: Supplementary to the Updated COVID-19 Maaori Response Action Plan*.
- 19 *April 2021*: Quarantine-free travel between Aotearoa New Zealand and Australia starts.
- 23 *June 2021*: Wellington moves to Alert Level 2 at 11:59 pm.
- 29 *June 2021*: Wellington moves to Alert Level 1 at 11:59 pm.
- 23 *July 2021*: Quarantine-free travel from Australia is suspended.

VACCINE ROLLOUT FOR GENERAL POPULATION (GROUP 4) BEGINS

- 28 *July 2021*: The vaccine rollout to the general population begins with invitations to book a vaccination sent to all New Zealanders aged 60–64 years.
- 6 *August 2021*: Invitations to book a vaccination are sent to all New Zealanders aged 55 years and over.
- 11 *August 2021*: Invitations to book a vaccination are sent to all New Zealanders aged 50–54.
- 12 *August 2021*: It is announced that all people of an eligible age would be able to book a vaccination by 1 September 2021.

SECOND NATIONWIDE LOCKDOWN BEGINS

- 17 *August 2021*: All of Aotearoa New Zealand moves to Alert Level 4 at 11:59 pm. Vaccinations are suspended for 48 hours.
- 18 *August 2021*: Invitations to book a vaccination are sent to all New Zealanders aged 40–49.
- 19 *August 2021*: The Prime Minister announces that Cabinet has approved the vaccine for 12–15-year-olds.
- 22 *August 2021*: It is announced that mandatory record keeping is being introduced for many businesses and events.
- 25 *August 2021*: Those aged 30 and over are able to book a vaccination.

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- 31 August 2021: All of the country south of Auckland moves to Alert Level 3 at 11:59 pm.
- 1 September 2021: Everyone aged 12 years and over is eligible to be vaccinated. The Ministry for Maaori Crown Relations: Te Arawhiti announces a \$1 million targeted funding pool to support iwi-led response planning, communications outreach, and support for vaccine uptake.
- 2 September 2021: Northland moves to Alert Level 3 at 11:59 pm.

RESTRICTIONS EASE OUTSIDE AUCKLAND

- 7 September 2021: The country outside of Auckland moves to Alert Level 2 at 11:59 pm.
- 8 September 2021: A Beehive press release states that the Government has re-prioritised up to \$5 million to provide immediate relief to vulnerable whaanau Maaori and communities during the current COVID-19 outbreak.
- 21 September 2021: Auckland and Upper Hauraki move to Alert Level 3 at 11:59 pm. The Government announces increased funding of \$38 million to support Maaori health providers in the COVID-19 response.
- 25 September 2021: Upper Hauraki moves to Alert Level 2 at 11:59 pm.
- 27 September 2021: The Government releases a strategy for a highly vaccinated New Zealand that outlines a high-level approach to the proposed next stage of COVID-19 response in Aotearoa New Zealand.
- 3 October 2021: Raglan, Te Kauwhata, Huntly, Ngaaruwaahia, Hamilton City, and some surrounding areas move to Alert Level 3 at 11:59 pm.
- 4 October 2021: The Prime Minister announces a roadmap out of lockdown for Auckland.

RESTRICTIONS EASE FOR AUCKLAND

- 5 October 2021: Alert Level 3 restrictions in Auckland are eased from 11:59 pm to Step 1 of Alert Level 3. Cabinet agrees to the use of vaccine certificates in Aotearoa New Zealand.
- 7 October 2021: The Waikato Alert Level 3 boundary is extended from 11:59 pm to include the Waitomo district, including Te Kuuiti, Waipa district, and Ootorohanga district.
- 8 October 2021: Northland moves to Alert Level 3 at 11:59 pm.
- 11 October 2021: The Government announces that health and disability workers will have to be fully vaccinated by 1 December 2021, with their first dose administered by 30 October, and all teachers and early childhood workers will have to be fully vaccinated by 1 January 2022, with their first dose administered by 15 November. Those who refuse to get vaccinated will lose their jobs.
- 16 October 2021: A national 'Day of Action' – a 'Super Saturday' vaccine drive – is held, with 130,000 people vaccinated around the country.
- 19 October 2021: Northland moves to Alert Level 2 at 11:59 pm.

COVID-19 PROTECTION FRAMEWORK ANNOUNCED

- 22 October 2021:* It is announced that Auckland will move into the new COVID-19 Protection Framework when 90 per cent of the eligible population in each of the three district health boards are fully vaccinated. A target of 90 per cent fully vaccinated is set across each district health board region before the rest of the country moves into the new system. The Government announces a further \$120 million fund to support Maaori communities to fast-track vaccination efforts and to prepare for the COVID-19 Protection Framework.
- 27 October 2021:* The parts of Waikato that are at Alert Level 3 move to Step 1 of Alert Level 3.
- 2 November 2021:* Upper Northland moves to Alert Level 3. The parts of Waikato at Step 1 of Alert Level 3 move to Step 2 of Alert Level 3 from 11:59 pm. The Government announces that it has approved funding of \$23.5 million for eight Maaori organisations and iwi to boost Maaori vaccination rates. The money is from the Government's new \$120 million Maaori Communities COVID-19 Fund.
- 9 November 2021:* Auckland moves to Step 2 of Alert Level 3 at 11:59 pm.
- 11 November 2021:* Upper Northland moves to Alert Level 2.
- 16 November 2021:* Parts of Waikato move to Alert Level 2. Vaccine passes are launched.
- 17 November 2021:* The Prime Minister announces the approach to transitioning to the Protection Framework, with Cabinet to confirm when the country will transition to the framework on 29 November.
- 18 November 2021:* A Beehive press release in relation to the Maaori Communities COVID-19 Fund states that the Government has approved \$46.75 million and signed 26 contracts to rapidly accelerate Maaori vaccinations across the country.
- 22 November 2021:* The Prime Minister announces that the whole country will move into the traffic light system on 3 December 2021.
- 24 November 2021:* A Beehive press release states that fully vaccinated New Zealanders and other eligible travellers will be able to travel to Aotearoa New Zealand from Australia without staying in managed isolation and quarantine from 16 January 2022 and will be able to travel from all other countries from 13 February 2022.
- 29 November 2021:* The Prime Minister announces which setting each region will enter the COVID-19 Protection Framework on.
- 3 December 2021:* Aotearoa New Zealand moves to the COVID-19 Protection Framework.

APPENDIX II

WITNESSES WHO GAVE EVIDENCE FOR THIS INQUIRY

II.1 CLAIMANT AND INTERESTED-PARTY WITNESSES

Claimant and interested-party witnesses who gave evidence for this inquiry were Wanda Lillian Brljevich; Natasha Clarke; Lee Colquhoun; Leonard Cook; Shelley Cunningham; Associate Professor Elana Curtis; Dr Danny de Lore; Rangi Teameamea-i-te-vai-o-hiro Elizabeth (Tammy) Dehar; Aperahama Edwards; Peter Fraser; Robert Roy Gabel; Kara Paerata George; Eleanor Hekekura Hamlin-Paenga; Professor Shaun Hendy; Tracy Hillier; Rosaria Hotere; Dr Peter Jansen; Dr Rawiri Jansen; Dr Bryn Carwyn Jones; Tania Kingi; Dr George Laking; Huuhana Lyndon; Tauri Lyndon; Moe Milne; Geoff Milner; Lady Tureiti Moxon; George Ngaatai; Pamela-Anne Ngohe-Simon; Daymon Nin; Bradley Norman; Karen Pointon; Merepeka Raukawa-Tait; Simon George Tiwai Royal; Di Rump; Dr Jin Russell; Waihoroi Paraone Shortland; Mike Smith; Andrew Sporle; Ronald Takarei; Prudence Tamatekapua; John Tamihere; Rowena Ngaio Tana; Haamiora Te Maari; Tania Thomas; Pita Tipene; Dayna Tiwha; Charles Waldegrave; and Associate Professor Siouxsie Wiles.

II.2 CROWN WITNESSES

Crown witnesses who gave evidence for this inquiry were Lilian (Lil) Marie Anderson; Dr Ashley Bloomfield; Ruth Fairhall; Joanne Lisa Gibbs; Minister Chris Hipkins; Grace Smit; John Whaanga; and George Osborne Whitworth.

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1 STATEMENTS

1.1 Statements of claim

1.1.3 Charl Hirschfeld, Tony Sinclair, and Barney Tuupara, amended statement of claim on behalf of Priscilla Sandys, her whaanau, and Roimata Maraе, 15 July 2017

2 TRIBUNAL MEMORANDA, DIRECTIONS, AND DECISIONS

2.6 Hearing stage

2.6.59 Judge Damian Stone, memorandum concerning accessibility protocol, 21 September 2021

(a) Waitangi Tribunal, Waitangi Tribunal Accessible Inquiry Protocol 2021, [20] September 2021

2.6.68 Judge Damian Stone, memorandum concerning request for special inquiry into the Crown's COVID-19 policy, 17 October 2021

2.6.70 Judge Damian Stone, Associate Professor Tom Roa, Professor Linda Tuhiwai Smith, and Tania Simpson, memorandum granting priority hearing, 23 November 2021

(c) Waitangi Tribunal, 'Granted Leave to File Submissions, Evidence and to Cross-examine', Microsoft Word document, 23 November 2021

(d) Waitangi Tribunal, 'Granted Leave to File Evidence – to be Taken as Read', Microsoft Word document, 23 November 2021

(e) Waitangi Tribunal, 'Watching Brief Only', Microsoft Word document, 23 November 2021

2.6.74 Judge Damian Stone, memorandum setting out attendance protocols for the 6–10 December priority hearing into the Crown's COVID-19 policy, 30 November 2021

2.6.75 Judge Damian Stone, memorandum concerning 30 November 2021 teleconference, 1 December 2021

(a) 'Updated Timetable for a Priority Inquiry into the Crown's COVID-19 Protection Framework', table of milestones and filing dates for priority inquiry, [1 December 2021]

(b) 'Watching Brief Only – Updated', table of parties with watching briefs and their counsel, [1 December 2021]

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2.6.77 Judge Damian Stone, memorandum concerning matters arising from the 6–10 December 2021 priority hearing, 14 December 2021

3 SUBMISSIONS AND MEMORANDA OF PARTIES

3.1 Pre-hearing represented

3.1.155 Geoffrey Melvin and Abbey Lawson, memorandum setting out Crown acknowledgements, 1 May 2018

3.2 Hearing stage

3.2.366 Donna Hall and Odette Ford Brierley, memorandum seeking special urgent hearing into Crown COVID-19 policy, 12 November 2021

3.2.413 Jason Gough, memorandum accompanying chronology of Crown actions, 30 November 2021

(a) [Anna McTaggart], ‘Chronology of Relevant Crown Actions in relation to the COVID-19 Pandemic’, table of Crown actions and their dates, [30 November 2021]

3.2.441 Felix Geiringer, joint memorandum on behalf of the New Zealand Maaori Council and the Crown, 5 December 2021

3.2.446 Donna Hall, Odette Ford Brierley, Philip Cornegé, and Felix Geiringer, statement of facts concerning Maaori and COVID-19, 8 December 2021

3.3 Opening, closing, and in reply

3.3.50 Donna Hall, Odette Ford Brierley, Philip Cornegé, and Felix Geiringer, closing submissions on behalf of the New Zealand Maaori Council (Wai 2644), 10 December 2021

3.3.54 Tom Bennion, Emma Whiley, and Genevieve Davidson, closing submissions on behalf of Taangata Turi and the Te Roopu Waiora Trust (Wai 2143, Wai 2575), 10 December 2021

3.3.55 Season-Mary Downes, Chelsea Terei, Josey Lang, Heather Jamieson, Huhana Rolleston, and Jessica Hita, closing submissions on behalf of Te Ruunanga o Ngaati Hine (Wai 682) and Te Kapotai and Ngaati Pare (Wai 1464, Wai 1546), 10 December 2021

3.3.56 Coral Linstead-Panoho and Kelly Davis, closing submissions on behalf of Te Roopu Taurima o Manukau Trust (Wai 2734), 10 December 2021

3.3.57 Karen Feint QC, Kelly Dixon, Lucy Tothill, and Tesa Va’afusuaga, closing submissions on behalf of the National Hauora Coalition (Wai 2575, Wai 2687, Wai 2943), 10 December 2021

3.3.58 Jason Gough, closing submissions on behalf of the Crown (Wai 2575), 10 December 2021

3.3.59 Paranihia Walker, Lana Underhill-Sem, Tara Hauraki, closing submissions on behalf of Te Ohu Rata o Aotearoa (Wai 2499), 10 December 2021

4 TRANSCRIPTS AND TRANSLATIONS**4.1 Transcripts**

4.1.10 National Transcription Service, transcript of priority hearing, December 2021

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A57 Dr Heather Came-Friar, Professor Tim McCreanor, Kerri Nuku, and Leanne Manson, joint brief of evidence, 27 July 2018

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(a) Andrew Sporle, comp, supporting documents to document D3, 30 November 2021
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D5 Haamiora (Sam) Te Maari, brief of evidence, 30 November 2021

D6 Tauri Lyndon, brief of evidence, 30 November 2021

D8 Dr Danny de Lore, brief of evidence, 30 November 2021

(a) Dr Danny de Lore, Dr Erik Andersen, Dr Teuila Percival, Dr Jin Russell, Dr Owen Sinclair, and Associate Professor Siouxsie Wiles, 'Joint Report on Expected Impacts to Maaori Children and their Whaanau from the Planned Shift to the COVID-19 Protection Framework', brief of evidence, 29 November 2021

D9 Peter Fraser, brief of evidence, 30 November 2021

(a) Peter Fraser, comp, supporting documents to document D9, 30 November 2021

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pp 14-17 Peter Fraser to John Whaanga and David Samuels, 'New Zealand Maaori Council Vaccination Proposal', letter, 4 October 2021

pp 18-19 Peter Fraser to John Whaanga, 'NZMC - Responses to COVID 19', email, 14 October 2021

D11 Michael Smith, brief of evidence, 30 November 2021

D12 Leonard Cook, brief of evidence, 30 November 2021

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(a) Moe Milne, brief of evidence (English), 2 December 2021

D17 Rowena Tana, brief of evidence, 30 November 2021

D18 Pamela-Anne Ngohe-Simon, brief of evidence, 30 November 2021

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D22 John Tamihere, brief of evidence, 30 November 2021

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(a) Dr George Laking, comp, supporting documents to D24, 30 November 2021

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pp 34–81 National Ethics Advisory Committee, *Ethics and Equity: Resource Allocation and COVID-19* (Wellington: Ministry of Health, 2021)

pp 82–104 National Ethics Advisory Committee, *Summary of Submissions: Consultation on the Draft Ethical Framework for Resource Allocation in Times of Scarcity* (Wellington: Ministry of Health, 2020)

D26 Bradley Norman, brief of evidence, 30 November 2021

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D30 Tania Kingi, brief of evidence, 30 November 2021

D31 Tania Thomas, brief of evidence, 30 November 2021

D32 Simon Royal and Rangi Dehar, joint brief of evidence, 30 November 2021

(a) Melissa McLeod, Jason Gurney, Ricci Harris, Donna Cormack, and Paula King, 'COVID-19: We Must Not Forget about Indigenous Health and Equity', *Australian and New Zealand Journal of Public Health* (2020), doi 10.1111/1753-6405.13015

D36 Pita Tipene, brief of evidence, 30 November 2021

D37 Geoff Milner, brief of evidence, 30 November 2021

D39 Dr Rawiri Jansen, brief of evidence, 30 November 2021

- D42** Di Rump, brief of evidence, 30 November 2021
- D43** Lee Colquhoun and Shelley Cunningham, joint brief of evidence, 30 November 2021
- D45** Grace Smit, affidavit, 3 December 2021
- D46** Lilian Anderson, affidavit, 3 December 2021
(a) Lilian Anderson, comp, supporting documents to document D46, 3 December 2021
pp 70–73 ‘Talking Points for Maaori Ministers’, word processor document, no date
- D47** Ashley Bloomfield, affidavit, 3 December 2021
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pp 1–5 Emily Harvey, Dion O’Neale, and Steven Turnbull, ‘Auckland Holiday Movement Patterns’ (Auckland: Te Puunaha Matatini, 9 November 2021)
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pp 10–15 Network Contagion Model Team, ‘Vulnerable Communities/Spread at AL2’ (Auckland: Te Puunaha Matatini, 2021)
- D50** Ruth Fairhall, affidavit, 3 December 2021
(a) Ruth Fairhall, comp, supporting documents to document D50, 3 December 2021
pp 33–52 Jacinda Ardern, ‘COVID-19: A Strategy for a Highly Vaccinated New Zealand’, Cabinet paper, [27 November 2021]
pp 60–79 Jacinda Ardern, ‘COVID-19: A Strategy for a Highly Vaccinated New Zealand – Report Back’, Cabinet paper, [4 October 2021]
pp 146–150 Michael Webster, ‘COVID-19: Confirming a Strategy for a Highly Vaccinated New Zealand’, minute of Cabinet decision, CAB-21-MIN-0421, [18 October 2021]
- D51** Christopher Hipkins, affidavit, 6 December 2021
(a) Christopher Hipkins, affidavit, 21 December 2021

