TE TIRA ĀRAI URUTĀ
NZ ROYAL COMMISSION
COVID-19 LESSONS LEARNED

# Te Tira Ārai Urutā

## Royal Commission of Inquiry into COVID-19 Lessons Learned

## Official interview transcript: Sir Ashley Bloomfield KNZM

***26 May 2025***

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| **Present:** | Grant Illingworth KC | GI | *Chair of the Inquiry* |
| | Anthony Hill | AH | *Commissioner of the Inquiry* |
| | Judy Kavanagh | JK | *Commissioner of the Inquiry* |
| | Nicolette Levy KC | NL | *Counsel assisting the Inquiry* |
| | Danielle Kelly | DK | *Counsel assisting the Inquiry* |
| | Andrew Sweet | AS | *Executive Director of the Inquiry* |
| | Inquiry Secretariat member | IS1 | - |
| | Inquiry Secretariat member | IS2 | - |
| | Sir Ashley Bloomfield KNZM | AB | *Former Director-General of Health* |
| | Victoria Casey KC | VC | *Legal representative for the All-of-Government Response – DPMC* |
| | Crown Law Office representative | CLO1 | - |
| | Ministry of Health representative | MOH1 | - |
| | Ministry of Health representative | MOH2 | - |

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| | [redacted introductory comments] |
| AH | So, Sir Ashley. Welcome, and thank you again. I recall the process for your appointment as Director-General of Health and I don't know if you remember, but Stephen McKernan said, "This is your time". He said that a couple of times. An incredibly prescient comment that proved to be, so just want to say on behalf of the Commission that we are extraordinarily grateful for the work that you did through that extraordinary time and how well you stood in the role you were appointed to, and served the purpose of that role so well. So I want to acknowledge the work that you did and the team that you gathered around you. We are conscious that this was an extraordinary time, with extraordinary stakes.<br><br>We are very much in learnings and looking forward. We need to examine a period through that '21, '22 year. We're very much interested in thinking about how we strengthen Aotearoa for the future. We are very much a learnings-focused Royal Commission and that's the ethos that we bring to this conversation and to every conversation.<br><br>What I'd like to do today is start with some general areas and reflections from yourself, before we move into some specific topic areas, again to get your general perspectives on |

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| | those. I'll be asking most of the questions and my colleagues will also have some questions. We're looking about two hours. So that's where we are. Is that okay so far? |
| AB | It is, and thank you very much for your opening comments, which I greatly appreciate. |
| AH | So look. The Phase One report, which is comprehensive, recognised that it was a game of two halves, and we are interested in that, as I said, the 2021-2022 period. As you look back over that period, in the headlines through that period, what would you say you think really right, and why? |
| AB | Let me answer that in two parts. The first is the ongoing response and the elimination strategy approach. And the second is the vaccination programme.<br><br>In terms of the overall response where the approach that New Zealand was taking, I think through into the first two-thirds of 2021, it was clear that we had in place all the elements that were needed to maintain the overall strategy, which was an elimination strategy, and we were doing that successfully in that we were able to effectively keep the virus out for long periods and if it did appear through some breach at the border – well it'll always be a breach at the border – then we had in place the testing, the contact tracing, the framework for response that got tested on a couple of occasions, but in particular in February with the small outbreak in Papatoetoe at the school, and that we were able to get around those small outbreaks quickly and effectively. So I would say, we had in place all the elements required to be able to deliver on what was the strategy, that elimination strategy, and I think that served us very well, you know through until later that year when it was clear a transition was needed to be made.<br><br>So, I think the other part of that is that the decision making and governance and leadership arrangements by that point were quite well set in place. And those had been through probably the first six months of 2020, there had been different approaches taken and those had settled into a pretty comfortable and useful arrangement with the COVID CEs Board, the external review committees playing their role, Cabinet decision making and the response Minister and then the vaccine Ministers.<br><br>So then let me move on to the vaccination programme, and I should have started by saying as I read back through the papers, and particularly the Minister of Health's response to the questions that are put to him by this phase of the Inquiry, it reminded me of just the enormous breadth and depth of the work that was happening, and as I read through the chapter, the response around the establishment of the vaccination programme and |

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| | everything that had to fall into place to effectively roll out a vaccine programme to our entire adult population, that was a huge undertaking. And I think the governance we put in place, the capability and capacity we built, the leadership of that programme, the networks we built, set the stage for a successful delivery of that vaccination programme through 2021 and into 2022. And of course, even as 2022 came around and we learnt more about the waning of the vaccine effectiveness, then we had to keep that work going with the roll-out of a booster programme as well. So I think, again, my memory prompted by reading through such documents, and just seeing the key elements of the strategy and being able to respond to maintain an elimination approach and then to roll out the vaccine as quickly as we could, and as equitably as we could, so that we could move out of that elimination strategy once it had reached a high enough level of vaccine coverage. |
| AH | Thanks. And I'd like to explore that a little more later, the thinking about and the thresholds around that transition period. So we'll come to that. As you think of that period, what do you think didn't go as well as you would have liked and how would you like to see that in the future? |
| AB | Well one of the things I've reflected on is actually more an organisational matter, and a people matter, and this related – and we knew it would happen, but the fact that the pandemic, the effort had to be so sustained for so long. And even at the time when the response seemed to be going well and we were COVID-free, we were in that Alert Level 1, for our teams that was not down-time because the vaccination programme was happening. The effort required even to maintain the country in that COVID-free state, as well as the testing and having all the capability and capacity, the policy work that was happening, and for my part, one of my things I would do differently right at the start would be to make sure one of my senior executive team members – and I've talked about this publicly – was tasked purely with pastoral care and in particular rotating people through those senior roles, because they were just so relentless and demanding. This of course was an issue right across the public sector as well. And I think if I reflect on the approach that the Defence Force took to the leadership of MIQ, which they rotated their senior people through with a six-month stint, I think that there's definitely a lesson to be learned there. However, it also reflected that we're a small country and that our public service, even when there's not a pandemic, has to cover the full breadth of functions that the public service, or the civil service, does in much larger countries. And I think it showed that we can mobilise, but that reserve, the depth – especially for a longer-term response – could use some thought about how to rotate |

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| | people in and out and reduce expectations in other areas as well. I think we did that well, but it's definitely something that I feel I didn't necessarily fulfil all my obligations to my staff, some of whom did burn out.<br><br>The other area that I've reflected on – and this goes particularly to the vaccine programme – is we had a huge focus on equity right from the start. And in fact, even from the start of the response, one of the biggest drivers of the response was the knowledge of what had happened a hundred years ago in the so-called Spanish flu pandemic and the terrible impact that had on Māori communities around the motu. So a key driver for us was how to protect our most vulnerable populations, which included of course, and as it transpired was like we anticipated, older people would be at high risk – it transpired they were at much higher risk of hospitalisation, but also Māori and Pacific Peoples, people with pre-existing conditions and who might be immunologically-compromised, disabled people and so on. So that was a key driver. When I go to the vaccine programme, we had a really strong focus on equity from the start. I'm not sure all that focus was necessarily recognised in some of the commentary about how the programme was rolled out. I do think about what else might we have done, and I think if there are lessons to be learned, it would be around how we could perhaps think earlier about what specific strategies might be needed to ensure that we did get that equity in the roll-out. And the reason I think that's important is arguably one of the reasons why the lockdown in the northern region extended perhaps longer than it might have needed to, was that we still had lower coverage amongst some of those groups. So whilst we had excellent coverage in our older people – and I should say that up until about July or August in 2021, our coverage for older people was higher amongst Māori and Pasifika than it was for non-Māori and non-Pasifika. And this was, in particular, due to the fact that the Government had set aside a quantum of vaccines for Māori and Pacific providers right at the start, and I think there was lesson there that actually if you enable those providers, they were able to both find and get consent for it and get high uptake. So we had high coverage there. But particularly amongst younger Māori and Pasifika, we had lower vaccination rates and it wasn't until later in the year that those caught up and then we had that level of coverage right across the population that then put the option of reducing those more stringent lockdown type measures and then phasing out the elimination approach.<br><br>So those would be two areas I would point to. |
| AH | Thanks, that's really helpful. As I think about that period and as I think about the transition to living with the virus, internationally and locally there was conversation about one of the |

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| | things we were trying to protect was the capacity of the health system to respond, and by late '21 it was still being asserted in Cabinet papers that primary and secondary and tertiary care didn't have the capacity within the system to deal with an avalanche of cases – avalanche is my word, not a Cabinet paper's – so given that the resilience of the system was a key predicator for our freedom to move, what do you think about the ability to invest earlier in the system, the health system itself, in its capacity to build resilience so that it could cope with surges and would have given us more options in terms of choices. This is an international problem, I don't expect an easy answer, but what do you think about that idea and how feasible do you think it would be in New Zealand. If we had a time horizon of one, two and then three years, so there was time to start investing, what do you think about that as a strategy? |
| AB | I can make a few comments there. First of all, just generally, if you think about the impact of the COVID pandemic and one of the advantages we have in looking back so that we can look forward, is that there was an in-time counterfactual in what was happening in other countries. And early on in the pandemic there was a lot of discussion about we haven't got the number of ICU beds that other countries have got, or ventilators, or staff and so on. Of course, what we saw was that it didn't matter how many of those you had, your system got overwhelmed if the virus got away in the community; and particularly with those earlier variants, the original native you might call it variant, and then the Alpha variant in particular, and Delta, which was also a pretty nasty strain. |
| AH | Yeah. |
| AB | So there was an understanding which we carried right through that actually however much you had in the way of staffing, facilities, intensive care response, even primary care, there was a very fine line between the system being able to cope and not coping. So that's the first point I make.<br><br>The second point is to your point about could we have started gearing up. Well, there are two elements to this. One is, there was significant investment and actually as I read back through the papers and saw that extra funding that was put into the health system to, where possible, strengthen or expand the workforce, to do upgrades to facilities, to enable hospital facilities in particular to deal with patients who might have COVID through changes in ventilation, addition of positive pressure, ventilation rooms and so on. There was that |

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| | investment made. But of course, the key determinant of the health system's capacity is the workforce and how and where that's deployed, and that's a five-to-ten-year investment.<br><br>The other thing is that there had been – and I can speak for experience here, having been a District Health Board Chief Executive from 2015 to 2018 – there had been quite limited capital investment through a period of about a decade. Aside from in Christchurch to rebuild some facilities post-earthquake, in particular the big main building there, there had been very limited investment in both upgrading facilities, so the replacement of facilities, but also new facilities. And at the same time there had been this sort of triumvirate of impacts – there was the limited investment in new facilities, DHBs, because their operational budgets were under a lot of pressure, tended to skinny down their capital budgets in terms of depreciation, so upgraded facilities wasn't happening but then the earthquake requirements came in as well, the seismic strengthening requirements. And again, facility building, as we've seen, a good example with Dunedin Hospital, these things have got quite a long lead-in time, but there was still some tactical investment in those.<br><br>I think the third element of this was the real area where a difference could be made once there was infection in the community was in the primary community side of things. And again, probably of all parts of the system, it's the primary care area that's got the biggest challenges in terms of workforce, both medical and other workforce. One of the key responses was to stand up that programme of work around primary community support. So that was an area where investment was made which I've seen the paper by Richard Beazley and colleagues which suggests that that did have quite an impact, even once the virus was out in the community and had wide infection from the Omicron variant, that actually our excess mortality was quite a bit lower than other countries saw when they got that first big wave in the community. I think in part because of that primary and community support programme that was put in place.<br><br>So, to summarise in response to your question, most of those investments have got a reasonable lead-in time. |
| AH | Yeah. |
| AB | I do have one idea that I have floated previously, and that is that in my experience through the pandemic it was quite amazing how many times that our Defence Force was put forward as the solution, including for example, the medically and health trained people in the Defence Force to, for example, support the vaccination programme. In fact our Defence Force got a very small, very modest health and medical component to it and one thought I |

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| | had would be, that could be an area that could be strategically invested in to not only help strengthen it within our Defence Force and our ability to deploy health related responses – particularly around the Pacific – but also to provide some of that redundant capacity that could be deployed in these sorts of situations. And I think that's something that merits a further look at. |
| AH | All ideas are on the table for us, so we'll take anything else you've got to offer in that space as well, thank you. Can I take you to an interview that you did with Paddy Gower in March of this year where you were reported as saying. "we should have listened more." And obviously that's an idea we're interested in as we think about the future and multidisciplinary advice streams, and we'll come to that a little bit later. Can you tell us a little more about what you were thinking about when you made that comment – assuming that's a correct report of your comment? |
| AB | Yeah. |
| AH | If you could to us about that, that would be helpful. |
| AB | Yes, so there are two parts to this. First of all, it was a general comment about leadership which I do quite a number of talks and presentations on, and one of the things that strikes me as a key leadership behaviour is listening and it's probably one that we can never do enough of. It's that idea that communication is a two-way exercise that does start with listening. And of course the communication part of our overall response was a really critical part of, I think, New Zealand's successful response and it played a key role in getting the collective action that was required from both the response side and a vaccination side. So it's something we did well.<br><br>The second part is what was in place to listen to and hear the different voices and the needs and so on. There were a lot of mechanisms in place. My particular reference here is once there started to be this fragmentation of the kind of solidarity, and in particular the circulation – and I think the best collective phrase is 'harmful, inaccurate information' rather than calling it other things. So I think that's actually the best term I've come across. Many people may not necessarily have agreed with that information but they perhaps just wanted to feel that their concerns were being heard, that they were being listened to. So what I wonder is if we could put in place more deliberate and structured mechanisms for that. One of the inputs that prompted me to say that was last year's survey on trust, the Acumen Trust Barometer. It's built on the Edelman Trust Barometer here in New Zealand which looked at |

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| | the introduction of new technologies like AI, gene technologies and so on, and actually people wanted scientists to be more at the forefront of communicating about these issues. But they also wanted – responses said they want to be explained the pros and the cons and they want their concerns to be heard and listened to. So what I was, in summary, thinking of is what sort of structure and more obvious processes might be put in place in the future that would allow us to do that to help, maintain and build trust. |
| AH | One of the things that we hear a lot is you'll appreciate formed a very broad range of views – one of the themes that we've heard from the centre is that there was a base position of not engaging directly with what were perceived as the – I'll call them the misinformation voices – that harmful and inaccurate is probably more an accurate phrase for certainly some of those voices. So do I interpret what you say now as actually a better strategy is more direct engagement and can you comment on whether or not there was a kind of thought that it was unhelpful to engage directly with some of those people that were, on the face of it, unwilling to hear counterarguments. |
| AB | It was really complex. |
| AH | And we appreciate that. |
| AB | The key focus of course for us was trying to get a really consistent, clear message out to the public through a range of channels and via a range of people communicators who might resonate with different parts of the public, different communities. The challenge with engaging with those who might be putting forward alternative positions – I think there's a difference between alternative views and views which may deliberately have an intent to spread harmful, inaccurate information. In the latter group you can spend an enormous amount of time and energy and effort – which we didn't have a surfeit of – engaging with them for very little benefit as they're not really interested in discussing issues. And this is, again, not unique to New Zealand, it's not unique to the COVID response and we can see it's still a major challenge globally, well beyond health. If I reflect back – and I don't think it was a deliberate decision to not engage, but the main approach was to continue through every channel we could and in every – through the opportunity to put forward the information that we were wanting to put forward that supported the approach and also, of course, the vaccination programme. And that was just where the effort was put rather than saying we won't engage over here. I should say that of course now nearly three years on, I'm still recognised and recognisable by people, and I still get some – a very small amount, I've had |

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| | it twice in the last week where people who had a different view, knowing I was going to be at a public meeting, have come to try and argue the case or have it out, it's probably a polite way to say it. So there was quite strong feeling as well at the time and I think for some people that does continue. The key thing for us was where we had the time, resources and felt that our best effort was put to.<br><br>In the roll-out of the vaccination programme a lot of effort was put into try to reach into those communities with a positive message and through a whole range of different channels. And for some communities, some individuals and some whānau, it might have taken four, five, even six interactions with people they trusted before they then did agree to be vaccinated. And so again, that was where the resource and effort was going. In many of those interactions and discussions, they would at the individual or whānau level be responding to questions or countering other information that people might have received that may have been based on inaccurate information. |
| AH | Thanks. I'm going to shift into some of the ways the system worked and the different advice streams were pulled together. [Informal conversation about temperature in the room.]<br><br>There was a massively complex machine and, as you've said, quite a complicated structure but we know that by 2021 orthodoxy in terms of the way the system worked was back in the sense of the way advice was fed into papers and papers were given to Ministers and to Cabinet and there was this organisational orthodoxy really appearing. Can we just talk to you about – there was a primacy of health [inaudible 30:45 …. ] debate and we'll come on to the livelihoods later. Tell me about your reflections on how health advice was taken into account in that dynamic as the tensions between lives and livelihoods started to become more obvious. In that time of change of the latter 2021 particularly. Just talk to us about how you felt the health advice was positioned within that scheme. |
| AB | If I could just make an initial comment. My view was, and still is, that it's not an either/or. It's not a mutually exclusive lives versus livelihoods. And right from the start of the pandemic clearly we had – this was a public health threat. That's why Health was the lead agency, just as if it had been a military threat, Defence and the Chief of Defence would have been the primary advisor to the Government on the response. The issue of livelihood, so the impact on the economy, was extant right from the start. It was one of the key focuses of the Government of course involved in the decisions about supporting businesses and individuals, but there were significant investments in that right through the pandemic at different times, including through 2021. As you've said, by the time 2021 rolled around, in a |

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| | sense it was as much as possible normal service was resumed in terms of Cabinet decision making and through that process the usual full gamut of advice was received to inform every decision that Cabinet made and ultimately of course Cabinet were the decision makers. Our input was to provide the public health advice and I think having reviewed one of the key DPMC Cabinet briefings from early October 2021, you can see there the full range of advice that is in there and the author of the paper was the Prime Minister and Cabinet, the public health advice was one input into that. So Cabinet was receiving advice from a wide range of inputs and in fact DPMC was commissioning, for example, the modelling directly. We weren't commissioning that out of the Ministry of Health. So often I didn't see that modelling before our advice would go. It was one of a number of inputs that DPMC was receiving and of course input from Treasury and other Government agencies. So I think the matters of lives and livelihoods and various other things – impact on children's education – there were a whole range of considerations that were informing Cabinet decision making, as happens at any time, and that's why you have Cabinet with Ministers getting advice from their agencies, including advice they might have had directly from their agency outside of what was captured in the Cabinet paper, to inform their position and then inform the Cabinet discussion. |
| AH | Okay. Can you talk me through late 2021 and into 2022, so we're talking a big change now. How do you articulate the key public health goals through that time? Is it as simple as – and nothing about this is remotely simple – obviously we went from elimination to living with the virus. Can you talk us through how the public health goals were changing through that period? |
| AB | Well in a sense the overall goals remained the same, which were to minimise to the extent possible the impact on hospitalisations – impact on hospitalisations and deaths, in particular, to minimise as far as possible the impact on the health system. So the overall public health goals were unchanged. What changed, of course, was the response because we were rolling out the vaccination programme and that was a key determinant – the level of vaccination – which was a key objective for the health system and our public health response was to get that high level of vaccination. But that was in service of those overall goals which was to minimise the impact of the virus, and particularly once we did transition out of an elimination phase into a suppression type phase. And it included, as I said earlier, standing up services in the community that would help to mitigate the likelihood, or reduce the likelihood, of people requiring hospitalisation, so easy access to Paxlovid and support to |

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| | help them isolate at home to, again, help reduce transmission in the community. So the public health goal was in a sense then changed through that. |
| AH | Okay. |
| AB | I should say there was one other one that was there right from the start and that was based on our experience from the Measles outbreak in 2019 and the terrible impact that had in Samoa when a case got into Samoa and there were over 80 deaths, many in children and infants – children under five and infants – and so a key part of our thinking, both through the response and through the vaccination programme, was to help ensure we didn't cause COVID also to get into the Pacific, and that we were supporting them in both their response and their vaccination programme, so there was a strong public health component to that part of the response and the vaccination programme as well. |
| AH | Great. Can I just explore that a little more. There's a quote, which I don't expect you to recall from a Cabinet paper many years ago, but it said that – this is about November '21 – "The risk of increasing case numbers is likely to be outweighed by the benefits of easing restrictions in the wellbeing of people living in the regions" – this is the Auckland thing – "particularly as vaccination rates continue to increase". Can you talk to us a little more about that conclusion? We just want to understand. |
| AB | So it's hard to respond to a short text taken out of the Cabinet paper and I'm not sure whether that was advice from the Treasury included in the paper, so whether it's citing Treasury advice, whether it's citing the overall DPMC position, whether it's citing one of the external review committees. |
| AH | It was public health advice from the Ministry. |
| AB | At the time. So I think what this really demonstrates is all of these decisions, and there were many of them and you can see going through the Ministry's response, over 20 bits even just in that period of the different levels and moves between different levels in the northern region from August 2021 onwards. Every single decision was informed by a public health risk assessment looking at what was happening globally, looking at the vaccination rates. So I would receive the public health risk assessment and there's a description in the Ministry document of all the people involved in that and then I would review that myself. I might take advice from Ian Town, my Chief Science Advisor. I'd talk to the Director of Public Health and I'd talk to some other colleagues out in the sector before then finalising the advice to Government, which was one input. |

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| | The only other comment I would make is that recalling that until really early 2022, we were dealing with the Delta variant outbreak. And the Delta variant was both more infectious than earlier variants but still could be coped with through an elimination strategy. But also tended to have quite a severe impact in terms of hospitalisation and death, which was different from Omicron when it came along. I guess the key point here is at all times through there, there was always a judgement call we made and even our advice – it was never absolute. I think over that period of time it did shift as we saw higher vaccination rates come through, as we thought about the capacity in the system and so on. |
| AH | So have you got any observations about the kind of balance of the role of the health advice in that general scheme? I think you've kind of answered it, but do you have any more reflections on how the balance, or the weight of the health advice, was deployed in the decision making over that time? |
| AB | Ultimately that was played out around the Cabinet table, and I can't really comment on that because I wasn't part of the Cabinet discussions. I think one other comment I would make is that our advice wasn't always taken. And sometimes the Cabinet decision would be more conservative than our advice on occasion, so that may have been an example where we may have been saying actually we're reaching that point where it may be starting to shift the other way, but the Cabinet of course take on board a whole lot of different inputs. |
| AH | Yeah. |
| AB | But just suffice to say – and I know there has been a view put forward and it was captured in the first Inquiry that the public health advice had too much weight throughout the process. I think if you look at the DPMC papers and Cabinet papers and the Cabinet decisions, I think it's clear to me, and it reminded me as I read through here, that actually it was one important input but it was just one input and the other considerations, particularly the economic impact, were a major input into Cabinet decisions, particularly about stringent measures like lockdowns. |
| AH | I want to talk a little about the communication of information to the public and just picking up some of the things you touched on before. We understand there was an MOU with DPMC whereby the COVID-19 group from DPMC would disseminate in an appropriate, accessible way, the vaccination and public health messages based on technical information provided from Health. How do you feel that process worked? Were you happy that the Health advice was conveyed as you would have liked? |

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| AB | I don't recall there was an MOU – that was a mistake. [Laughter.] |
| AH | These are right for the future. |
| AB | If there was an MOU, it was probably the most effective one I've ever come across in my career because something actually happened as a result of it. Look, I think we developed a really good working relationship. The process was really rigorous around ensuring that there was sign-off around the content on the public health side of it. And for really significant messages, I personally was involved in ensuring that the public health messages were appropriate and that the information was accurate. So I think that was one of the key parts of the system that worked really well. |
| AH | Good. Okay, thanks. So a slightly different matter. On the phase one report, in the phase one report, the Phase One Commissioners noted that having heard that key policies were developed by a small group of decision makers and advisors with little scope for broader input, do you have any comment on that? |
| AB | I'm trying to think what key policies might have been referring to there. That's not my recollection and I can remember in a range of forums having the key policies discussed, whether it's in the COVID CE's Board which Brook Barrington chaired as the Chief Executive of DPMC. There were the usual mechanisms for giving responses from other agencies into Cabinet papers, as you can see from of the examples there. And of course the Government also did set up these external review groups which there were three or four at one point, which also provided independent streams of advice. And I daresay that there was a lot of other advice that the Government received. Some of it was even solicited. A lot of it came directly through the media. So I think there was a lot of input into policy decisions through both the formal Government policy development processes, but also through other channels, and I certainly experienced on more than one occasion where our advice would be challenged. There would be different views perhaps on the public health advice we might be putting up to inform the key decisions by Cabinet. |
| AH | Okay. So thinking about the role of the Director-General of Health, where you stood at the absolute heart of this incredible storm, do you think that you had enough responsibility? Are there areas where you think you could have had more or less? This is a kind of personal reflection for you. You had a lot on. Do you feel like there were areas where you could have less or more control? You handled many exemptions, for example. There were boundaries |

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| | – in terms of the way that meant you could work, would you push some things away or bring some things closer? |
| AB | So I think I'd distinguish the three parts of the role. One was being the Director-General of Health and Chief Executive of the Ministry of Health, so managing the organisation and actually early on in the pandemic I handed over those responsibilities to my Deputy Director-General of Corporate, so the Chief Executive type responsibilities, managing the organisation. One of the reasons I did that was because of the second part which became obvious in the first couple of months, and I think it was particular to the fact that I was – not just that I was Director-General of Health but that I was a public health doctor with a long career in the health system, including as a District Health Board Chief Executive, and having done quite a lot of work, communication work, through my career, and so I think that's probably something that was, if anything, more personal about the fact that I was in the role at the time and it transpired that I became a key part of the communication response. And it may be that in another time, that would've been the Director of Public Health or the Ministry of Health Chief Science Advisor or someone else. I think that part of the role was as much a reflection on my personal and professional background as anything, and I just happened to be in the role, I happened to be Director-General of Health. If I'd been Director of Public Health I might have been doing that role even if I'd been in that role.<br><br>I think the third thing, and this goes to the issue of exemptions and border things, is of course in that case I was executing the role in a legislative hand. So yes I looked through all of those and signed them, but I didn't look at each individual exemption, I relied on the advice of specific advisory groups or expert groups that had been set up. And sometimes I'd question particular things and sometimes there was some line calls on certain individuals, for example, around exemptions or particularly vaccine exemptions that I would talk through with perhaps the Chair of the Committee. But in those instances it was less about me as a public health professional, it was more just me executing the role because I happened to be the Director-General of Health and it was a legislative sort of hat I was wearing rather than making all those decisions individually. |
| AH | Sure. Thanks. The comms point you just made, can we talk a little bit more about that at the beginning, not so much your role but more broadly with the communication of information to the public, goes to context really. People have talked to us about science talking in terms of probabilities. But some pandemic messaging was expressed in absolutes – you'll appreciate we hear a range of views – the vaccine is safe and effective, for example, as |

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| | opposed to the vaccine meets safety standards and the benefits outweigh the risks. This is a general question really. How do you balance explaining the uncertainty inherent in some aspects of science with the need for clarity when communicating with the public? I think the vaccine roll-out is a really good example of that where we want people to be confident enough to have the vaccine. So can you tell us about that balance? |
| AB | Yes, and I think it's a really good example. The first message about the vaccine is safe and effective is of course designed to be the headline message, and that might be what would go out in a comms, what one might lead out with. I saw my role as then explaining why we think it is, why believe it is, and why we believe the benefits outweigh the risks. If I was talking about the vaccine being effective, I would be talking to – there is a study that's been done, a randomised control trial, and it's shown that the vaccine's – 95% of people will not be hospitalised if they're vaccinated, and it would reduce the likelihood you might transmit the virus by 50%, so I would be attempting to use specific information. And one of the things that became really apparent to me is how discerning people are. If you provide the information and if you stay and answer all the questions, then they understand that safe and effectiveness is not an absolute. It's an overall message, and they understand that there is a probability implicit – especially if you then go on to explain and answer questions about the effectiveness in terms of percentages – and this is a very important part of health communication, risk communication is a real challenge. I saw my role in particular to follow – and sometimes to follow up the political messaging with that more nuanced detail from the scientific perspective. |
| AH | So to that, one of the things we see internationally and locally is this tension between the scientists presenting the information or the politicians presenting the information. And obviously in the crisis you had a bit of both. How do you feel that went? Looking forward, do you think it's preferable to have a mixture or would you have perhaps more science and less political views? What do you think about that? I'm not wanting to give you an answer, I'm trying to give you a question. |
| AB | Sure. |
| AH | We're just conscious that balance exists and what do you think about that? |
| AB | I think it's for others to judge whether it worked for us here in New Zealand and also I think it's reasonable to compare how effective it may or may not have been here in New Zealand and what impacts it had with how it worked in other countries. But the model we used of |

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| | politician plus a lead science or public service science commentator was one used by many countries, particularly the Five Eyes countries, and I had a chance to meet with the people who were in similar roles in those Five Eyes countries and some other jurisdictions. So that was a model that was used and seemed to be quite effective. I think here in New Zealand, my experience was that both perspectives are needed. Because the big decisions are political decisions, as they should be. |
| AH | Yes. |
| AB | And the strategy and the direction are matters for the Government and then every time I did my more than 300 standups, I was trying to be very careful about making sure I was speaking as the scientist, the public servant, not as the politician. A good example here is I didn't use the phrase 'team of five million'. |
| AH | No. |
| AB | That was the Prime Minister's phrase and one she used, and I was very careful to use – I did come up with some things, some idea, that then maybe the politicians would pick up on, like the issue of – I came up with this idea of remember people are not the problem, it's the virus that is the problem, people are the solution. Politicians might have picked that up. But that was my response where people who might have got infected, we'd get a pile on, on social media, just to try and remind everyone actually don't blame the people, it's the virus itself. Did we get the balance about right? I think that's for others to judge. Again, just to emphasise it was a model that many countries deployed and it seemed to be effective in terms of that really significant communication in a global crisis. |
| AH | Yeah. In a personal situation I think you handled that presentation role phenomenally well and consistently throughout actually. And I don't recall seeing any steps, if any, in fact from you at all. I think your ability to hold that science space and not jump into the politics was very well done, particularly given the pressure that you were under from some around you. I think you did that incredibly well. |
| AB | Thank you. |
| JK | Anthony, it's nearly an hour. Do you think we should have a quick break? |
| AH | Yes, that's a good idea and yes, I was coming to a break in my head. Would you like a five minute break now? |
| AB | I'm actually fine but if you need to do that then, or if you would like to, that's fine. |

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| AH | I'm happy to carry on if you're happy to carry on? People happy? Okay, so sing out if you want a break in the next 20 minutes or half an hour.<br>You've already commented on mis-and-dis-information. |
| AB | Yes. |
| AH | I've got a question here which you may not need to add much more too. If I don't ask it, I may regret it later. Do you have any opinions on how to address mis-and-dis-information. Are there any approaches you found particularly effective? I note you've suggested something earlier in terms of a more structured way to engage in that space. Have you got any other comments to add to that? |
| AB | It's a major issue. And it's not just an issue for COVID. It reflected a whole lot of global trends that all then came to a head during COVID. I should say that the main approach we took was, if I could describe it – I didn't use the word earlier on, but to try not to be too distracted by that, but to just stay really clear and really keep pushing through a range of channels. It's like making sure our main effort was that wherever people went, they would see accurate information, rather than us trying to spend a whole lot of effort responding to inaccurate information. This is a particular challenge around vaccines. The mis-information and harmful inaccurate information around vaccines has been around for ages. Of course it really came to a head through COVID because of the importance of vaccination responding to the pandemic and also because it was playing out at a time when social media channels which hadn't been there in earlier times when there was mis-and dis-information about vaccines were just such a fertile channel for those to be spread. So in the late 1990s when I started my public health career we had a Measles outbreak in Auckland and we responded to it. And our vaccination rates then for tamariki Māori and Pasifika were quite low and the anti-vaccine groups had quite a loud voice. What we realised was that the more you normalised vaccination and the higher you got your vaccination rate, the more those voices actually diminished. They weren't actually as powerful as it appeared they were. So rather than focusing on trying to respond to those voices and the mis and dis-information, we put our effort into actually vaccinating people, our children, through the 2000s and peak tamariki vaccination rates were around 93%, including Māori and Pasifika and non-Māori and non-Pasifika have all been above 90% by about 2015. Again, I think one of the really key strategies is to focus on what your game is – it's like a sporting analogy there, rather than trying to second guess what the others are doing on the other side. Have your game really clear. Be |

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| | prepared to flex if you need to, but be really clear about what your objectives are and then focus on that rather than being distracted too much by the mis and dis-information side of things. |
| AH | So as an adjunct to that, you talked about the model and the Five Eyes that politicians and scientists together being quite a common theme. Just thinking about the public facing communication, because it was often conveyed by and alongside Ministers, it has been suggested to us that this politicises health messaging. You've described the lines that you ran and you lived that, which I think kept that safe care but do you have any reflections on that? So the Minister's giving public health advice and the perception of politicisation of public health advice and whether you would make any suggestions for the future in that way. |
| AB | There are two issues. One is there is a risk of that happening and we were aware of that risk and a really key thing for me was maintaining my reputation and ability to communicate. Because what we were trying to do was build trust. Trust was such a critical element. It requires honesty, reliability and competence. So the latter bit would be why I spent three hours preparing for every one, so I needed to come across as if I knew my stuff. The reliability was turning up every day and then the honesty was really important. I think that's the bit that, again, is a perception issue – which is the second issue – is a perception that the health advice is being politicised. I think there's a difference between it being communicated by politicians because they were political decisions, and being politicised. I think my presence there, and likewise that model in other countries was to help to reassure. The feedback I received is it did reassure many, many people that actually there was substance behind it and I didn't stand up there and contradict the politicians beside me, but sometimes there would be perhaps a different view. And we would sort that out beforehand and I would say look if I get asked a question about this, I will be saying X, just letting you know, because people will know if I hesitate for a second, so I need to – so we were clear about the risk but also very, very clear and the politicians and their advisors were extremely respectful of the need for me to maintain my – not just maintain my political neutrality but to be seen to be maintaining that throughout. So that was a key part of our effort. |
| AH | Yeah. And well done on that. Can I take you now to some conversations about elimination strategies and vaccination strategies in a little more detail. Again, we're thinking about the future. You've talked a lot about this already. Do you have any further reflections on the elimination strategy as a strategy, and also can you just comment on, for a really highly |

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| | transmissible variant, is it the right strategy. I realise it's a hypothetical because there are a million moving parts around the question but give it your best shot. |
| AB | So the elimination strategy was one that – when we went into the first lockdown, which was a response to what we could see happening internationally, that wasn't the strategy. We didn't care about that. The strategy was to aim to flatten the curve was the language, to try and get down to a number of cases that we felt could then be managed through normal public health – regular public health measures like test, trace, isolation, quarantine. And it wasn't until we saw the extent of the impact of the lockdown and people effectively isolating and preventing the chains of transmission that then the idea of an elimination strategy was able to be both conceived of and then realised. So that strategy in fact came into being and was developed during the first lockdown, and then that became the approach.<br><br>I think the other thing to recall is that in March 2020, all the experts, everyone with expertise around the world felt it would be a minimum of two years – possibly up to five before an effective vaccine would be developed. So we were already thinking well gosh, what's the long game. And the interesting thing is we had very relatively effective and safe vaccines – more than one – within a year, within about nine months, it was extraordinary. And so actually our ability to then contemplate different approaches other than elimination was actually brought forward. It would have an even bigger challenge and probably not possible to maintain an elimination strategy for even longer than if we had been waiting for a vaccine and that would have required a re-think. We got to that point where it was quite challenging, that exit out of elimination. But there's no doubt that – and we weren't the only ones to take an elimination approach, but there's no doubt than an elimination strategy can and should be part of the toolbox now. It's definitely got its place in a toolbox. The question of whether you could do with a highly transmissible variant – you just couldn't, and in particular the thing that changed as the variants evolved was the incubation period. It just got shorter and shorter. For the initial native variant, it was about four days. And that gave you time to identify and isolate contacts, and that time just got shorter and shorter. And Delta was right on the cusp. But once the Omicron variant came along, because of that very short incubation period and its high transmissibility, elimination wasn't possible. So it's not an approach that you could deploy in every situation. But if you've got a situation with a reasonable incubation period and a manageable level of transmissibility, which the earlier variants had, then it's definitely an option that should be on the table and New Zealand and a number of other |

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| | jurisdictions have shown if you want to take that approach, here's how you can go about doing it. |
| AH | As we move along that continuum from transmission to suppression, was there a clear point where that shifted? Talk us through when that change occurred or was it an accumulation of changing information and patterns of behaviour of the virus – we had the native, we had Delta, we had Omicron and through that Delta-ish period, we started to shift. Was there a point at which it became clear that we're now moving to a different strategy? |
| AB | I don't really recall the details because it was – we were responding every day to what was happening. I think that if you look at the sequence of events as they are laid out, I couldn't identify a single point in there where suddenly a decision was right. It was a series of unfolding events situation. Vaccination rates were getting higher, we were looking at what was happening in other countries. I think the Cabinet paper from early October shows what was happening in different countries around infection rates and mortality rates, vaccination rates. So I think what was clear is that there needed to be a shift in the overall strategy from elimination to suppression. Of all the decisions, the hardest one to make, at about just about exactly what point that was. What was the right point to make that shift. |
| AH | Okay. I want to talk about some vaccination strategy questions and then start exploring the 90% idea. So we're just going to have a bit of a pathway leading us to the conversation now. We talked to a range of voices. We know that from mid-to-late 2020 a safe and effective vaccine provides the best opportunity to protect individuals from harm and we have in fact seen that deployed successfully. We have submissions to the Commission suggesting alternative strategies may have been preferable. Can you talk us through why vaccines were considered the best strategy against COVID-19? |
| AB | The key one is vaccination is an extremely well proven way of preventing deaths from infectious diseases. Last year the WHA estimated that in the preceding 50 years 150 million lives had been saved worldwide, or there had been 150 [million] vaccine preventable deaths averted in that previous years and 100 million of those were in children aged under five. So vaccines are an incredibly effective way of reducing the impact of infectious diseases and particularly in responding to outbreaks of infectious diseases, whether that's, for example, a Measles outbreak which is highly infectious – more infectious than COVID, or of course in a pandemic. That was considered as the – not just the best way to protect people but the best way to actually try and to return to a normal way of life in response after a major global |

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| | health crisis. I think that the explanation for why vaccination was, just the track record in the effectiveness of vaccines in preventing deaths and hospitalisations from infectious diseases. I'm just checking that that's – it feels like I'm stating the obvious. |
| AH | You are, but that doesn't make it incorrect at all. That's helpful. Can I supplement though again. We too have heard a range of voices. It picks up a little bit March 2020, three to five years, possibly no vaccines. So, are there realistic alternatives at a population level for the vaccination programme? |
| AB | Yes, there is a realistic – well, there is an alternative, and that is that you allow people to acquire immunity naturally, in other words, through the population, people being infected and many people getting seriously unwell and dying. So that's the alternative course and you build immunity and of course what we have in our population and in most countries in the world is a combination of hybrid immunity. Many people have been naturally infected and have been vaccinated as well. So that's the alternative. Certainly for the first 12 to 18 months of the pandemic it was an alternative of many governments, including New Zealand's, deciding they didn't want to pursue. |
| AH | And one assumes that's because of that population fatality impact. |
| AB | Totally. You've got a population that's got completely naive immune system. Everybody is in a naive immune system to a virus that we didn't really know the impact of, including as it kept changing its variants and as I said earlier on, there was in a sense an actual experiment where we saw what was happening in countries where there was a high level of community infection early on in the pandemic and it had a devastating impact. |
| JK? | Could I ask a segue off that. If we didn't get a vaccine, because we obviously had other strategies like social distancing for example, PPE, we had lockdowns and mandates, so there were other strategies. What would it have looked like if we never got a vaccine do you think, in terms of reliance on those strategies? |
| AB | I don't know and I think I was making this comment earlier on, that it would have been a very different game because I think it would have been impossible for a whole lot of reasons to maintain an elimination strategy right through for three to five years, and so different approaches would have been considered. And even in that first year to 18 months, of course our knowledge of the virus, our understanding of the effectiveness of different non-pharmaceutical interventions like physical distancing, use of masks, recalling that early on in the pandemic there was an assumption that the virus could be transmitted by droplet |

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| | spread so we didn't masks played a role, but as it transpired they played a really, really important role so yes, use of masks, physical distancing, support for people to stay at home if they were unwell, all of which were deployed, would have become – as well as contact tracing, testing contact tracing, isolation, quarantine, we would have had to rely on those non-pharmaceutical measures and really worked out how to hone those if we were to shift from an elimination approach into a non-vaccine, suppression approach. |
| AH | Thanks. |
| AB | And I should say, if I can just add a comment, we may need to do that in the future because it was an absolute gift that we had vaccines so quickly in this pandemic and that's an important lesson for us to take as well, is what we learnt about how you can get high mask use, you can get people voluntarily physically distancing, staying at home if they've got support, so they're all things that we did deploy effectively as well. So that's just as important that we take that lesson and embed it in our future pandemic plan. |
| AH | Great, thank you. Can I get you to comment on whether you consider the degree of vaccine hesitancy experienced during the pandemic was predictable and did the Ministry plan for that? |
| AB | Yes it was predictable there would be some people – and I think to distinguish between vaccine hesitancy, distinguish from that and then the much smaller group of people who just actually for a whole range of reasons did not want to be vaccinated, do not believe in vaccines, do not feel that they had a role or that this was a safe and effective vaccine. I think the planning was in recognising that the first 60 or 70% of the population, as I describe, be crashing the booking system at one minute past midnight, trying to book their vaccine as soon as possible, and then as with childhood vaccination, so maybe it's about maybe even 70 to 80%, then the next 10 to 15 percent or maybe the next 5 to 10, you've got to put extra resource and you've got to make it easy for them to get it, that's why there was pharmacies, the mass vaccination, the centres and events. And then there's that final, probably to get over 90% and between 90 and 95, these are people who don't have a fundamental objection but will require quite a lot of work often from –like Māori and Pasifika providers to get to them. So in a sense we had anticipated and planned for hesitancy amongst – a reluctance to just show up and be vaccinated immediately, or a whole range of reasons for not doing that. We had anticipated that and planned for that in the roll-out of our programme through a whole range of initiatives to access, provide access, for those groups who might have been |

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| | hesitant, who may have required access to be made really simple for them, because of their life circumstances, just make it as easy as possible for them. So yes, we had anticipated it and I think the fact that we got over 90% of the population vaccinated rate amongst adults was – that didn't happen by accident. |
| AH | Okay, thank you. Can I talk a bit about the use of vaccine mandates and to what extent did they contribute to overall vaccination numbers do you think? |
| AB | The mandates were for specific groups and for each group there had to be a justification as well as an assessment of BORA matters and so on – Bill of Rights matters. I think they played an important role in getting vaccination rates up to a really high level amongst those groups, and the groups were selected because of the significant role they might play because, for example, in the case of healthcare workers they were taking care of people who were vulnerable, they were also working in services where if you had a lot of the staff infecting each other and then going off sick, it would really compromise delivery of those services which would compromise the overall response. I think the mandates played a role in getting us – the difference, once you get over 90%, even the difference between 90 and 91 or 91 and 95 is quite significant in terms of the settings these people were working in and the likelihood that they might get infected and/or become seriously unwell and die, and these were people who were also, because of the nature of their work, were at high risk of getting infected. So there was a good reason to want to protect them as well. So overall, I think the mandates did play a role. We had high vaccination rates already by the time the mandates came in but they did play an important role in getting us up to that level, particularly for those workforces where the difference between 85 and 90 or 90 and 95 was really important in terms of the ability of those workforces to do their job, and reducing the risk that they would infect other people. |
| AH | Just reflecting on the impact the mandates had and the subsequent tools that were used in that space to encourage people or require them to get access to certain things, for example, as we think about the future, what would you say about – so moving from the specific high risk groups that you've identified, to think in that more general space, as we think about the future, what do you think about the use of mandates at a more general level as we think about the recommendations that we might choose to make about what tomorrow might look like? |

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| VC | Can I just clarify your question. So you're talking about a hypothetical where there might be a population or a mandate, for example? |
| AH | Or variations on that theme. |
| VC | The hypothetical. |
| AH | Which might be expressed – yes, hypothetical. I'm interested in your views, Sir Ashley. |
| AB | I think the key point here is that these are really big decisions that should not be taken lightly and a really thorough process needs to be followed that does consider the full gamut of considerations, including particular Bill of Rights considerations, so the process that we did follow. So they're not something to be used lightly, as they weren't through COVID, and a really robust process, both for determining the use of mandates and for their ongoing review to determine whether they're still justified and required is really important. |
| AH | And again, as we think about things in the toolbox for the future and the possibility of mandate and mandate subsidiary tools which are deployed for a I want to keep you safe so that you can keep delivering a service, I want to think about reducing transmission, I want to increase uptake of vaccines, would you think in the future that those three things are all viable for the use of mandate and mandate related tools? Do you think they really help uptake of vaccines for example? When you think of those trade-offs, how would you suggest we think about those? |
| AB | I'll add one other in as well, 'cos one other really important consideration was the views of all the people in those groups who had already been vaccinated and who I think rightly might have had a reasonable expectation that their colleagues around them would also be doing everything they could to reduce the risk that they would infect the people they were caring for perhaps and/or infect their colleagues. So that's a really important part of the consideration. I think the only thing I can say is all those factors have to be considered incredibly carefully and like most, if not all, government decisions, including big policy decisions, at the end of the day there's a judgement involved that needs to take consideration of all the relevant factors. And I just wanted to add in that other factor as well, which was a really important consideration. |
| AH | Yes, and one that we've heard, so thank you. Can I take you to lockdowns and have a little bit of a conversation now about the 90% threshold, and I want to come to the Doherty report, mainly to think about options and trade-offs as we think about the use of lockdowns |

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| | and extended lockdowns. So that's where we're headed. Can I ask you first to talk about the 90% threshold and tell us about that, how it was arrived at, and options that were thought about. |
| AB | I never thought of the 90% as a threshold per se, and I'm not sure if it was talked about in that way, isolating target, so it was more a goal or a target. And in part targets, like in the health system, are there to provide an aspiration and there were some reasonable science behind 90% and it was a target or a goal that a number of organisations and people got behind as well. The other thing, if we'd had a target of 70%, which as it transpires was probably not high enough and we did have the advantage of course of being – it's often a good place to be is slightly behind others to see what's happening in those countries, so we could also watch and see what was happening in countries that did have slightly earlier rollouts or faster rollouts for various reasons, mostly because of access to the vaccine. So 90% was both an aspiration to get to, to help lift us as high as possible and often when I was talking about it, I also didn't want to stop at 90, I didn't want to see well we've hit 90, that's it, everything's going to be okay. So the intention was to have a target that we thought was feasible that we could use for the purposes of planning for the programme, for the rollout, and that we thought would make a material difference in terms of reducing the burden of disease and really provide an option for moving into suppression. That didn't mean that was the threshold for moving into a suppression phase, in my recollection it was there to provide a rallying point for us to get as high a vaccination rate as possible. And even by the time that – so when the target came long, we already had higher rates amongst our over 65s in some areas and for some groups it is right up in the high 90s, which of course is good. |
| AH | Again, we're thinking now about the trade-offs. The Doherty report, which was August '21, think of a modelling, parameters – there are some interesting graphs in it though as it talks about – and I don't know if you've got that report with you? |
| AB | I don't have it with me. I received it electronically on Friday and I've had a chance to have a very quick look at it. And I should say, I don't recall that we saw this report at the time but probably, if I didn't see it I'm sure – because we had daily communication with our … |
| AH | It's really – I want to ask you about it as a framework for ideas and a framework for the trade-offs and what the report was signalling was, is at different – and I'm grossly simplifying – at different vaccination levels and we'll just take a general population cohort, ignoring young people for the moment, there are trade-offs to be made in whether you can |

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| | effectively get a way of suppressing the growth of the vaccine in the community by using different public service health protection measures, so social distancing, and Australians in the different states naturally behaved differently but they had an array of tools that were deployed here in terms of gathering limits, go to work, go home, do we do curfews. So that array of tools that could be deployed in conjunction with, or instead of, degrees of lockdown. So the report is generally suggesting there is some flexibility within the deploying of those tools – depends on transmissibility, it depends on the [inaudible 1:31:05] and depends on your base population level of herd immunity. But they're saying actually for the difference between 70%, 80%, 90%, it is very much a gliding scale and at 80%, for example - and it's more of a hypothetical – you could deploy aggressive public health service measures short of a full lockdown and achieve something similar to what you're achieving for a lockdown. A lot depends on transmissibility. So Delta, possibly not such a helpful idea. Omicron. So can you talk us through, as we think about that extended lockdown in Auckland, for example, what do you think about – if we were to consider that for the future, what do you think about being able to deploy those other public health service measures which require, of course, cooperation from the public, as a way of shortening that lockdown, notwithstanding that we weren't quite hitting the target that we were after. |
| AB | So as I had a quick look through this paper, and the first thing that struck me is yes, of course, modelling is a really important input into the decision making and I think that's why we used it throughout and in fact even the decision to go into that first lockdown was deeply informed by some modelling from Imperial College, London that showed what would happen, and you can see in the Cabinet paper from early October there's the modelling from Te Pūnaha Matatini which was commissioned directly right through to do modelling, to look at exactly these things, and of course the difference between Australia and New Zealand is similar in a lot of respects but a lot of it is based on what assumptions you put into the model, and they put in some assumptions here as you've alluded to. So the first thing that strikes me is modelling of this nature – and this is quite sophisticated, it's been really well reviewed, peer reviewed, so it's a really important input into decision making. But the second is just that point. It's an input and as you've already said, it depends where you are, what the time is – what the nature of the virus is sorry – and in many respects what they're talking about, these graduations of public health measures, was what the alert levels did anyway, so in a sense this advice was – the conclusions they reached were embedded in the whole alert level framework, were depending on what was happening, including vaccination |

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| | rates. As we went on you could step down the alert level before we transitioned to the traffic light system, you could step down the alert level with less stringent but still quite constraining public health measures in space about size of gatherings, use of masks and so on, whether shops could or couldn't open – which shops could or couldn't open, whether schools were open and so on. So I think the modelling is actually very consistent with and supports the approach that was taken, which was that alert level approach.<br><br>The other thing I think we can learn for the future, can deploy in the future, we've now got those models and the modelling techniques much better refined and ready to go to help inform decision making from early on and really start – and be able to model all sorts of different variables and have different assumptions to help inform decision making. Again, if I just look at that October Cabinet paper, the other key inputs was looking at what was happening in other countries. So the modelling's one thing. It's a bit like military strategy. It's fantastic until the first contact. So we're able to complement the modelling and our local modelling was included in the paper as well as looking actually what is happening in other countries with different levels of vaccination rate, with different population densities, with different infection rates and so I think that goes to the point of making sure you're gathering all the inputs to inform the best decision at the time. |
| AH | Thank you. Can I just take you to the idea that – there was a conversation that started happening around the vaccine waning effect, which you've mentioned, and so there was that period where you were trading off, where increasing vaccination rates, we're aware of a vaccine waning effect, we're still extending a lockdown. Did that result in a reconsidering of that target or how did you factor in the vaccine waning knowledge that was growing into that decision making process around the value of that extra week and the next week to try and lift the target itself, because there's an argument that the increase in vaccination rates and the vaccine waning effect effectively neutralised each other in terms of overall impact for that target purpose. Can you just talk us through that? |
| AB | I'll start by saying I don't recall the extent to which this was part of our discussions. There are two comments to make. The first is, of course, we didn't know what would happen with vaccine waning until – it was happening in real time and so we were learning about it, including from other countries, and therefore the second point is then rather than necessarily saying well that's influencing a point at which we can make a decision, I think that actually the vaccination programme had to pivot, which was to continue to try and get as many people as possible vaccinated with the first two doses but also then of course our |

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| | highest needs and most at risk groups that had been vaccinated earlier, then we needed to stand up the booster programme for them to get older people, to help combat that waning immunity. It's separate from, and perhaps to inform the decision around whether a lockdown should or shouldn't consider because waning immunity in our highest risk groups was arguably something that should have, and I'm sure it did – I don't recall the details – inform about, inform the length and duration, the duration and intensity of any lockdown. I think a key point here is it emphasises that these things were happening in real time and so actually the most significant response was standing up that booster programme to vaccinate or re-vaccinate that high risk group of people. |
| AH | Okay, thank you. Just doing a time check. We've got about another 20, 23 minutes to go. I think we've dealt with those two. Can I take you testing and tracing briefly. In relying on PCR testing for much of the response, we effectively in New Zealand faced trade-offs between testing accuracy, accessibility and speed. How should decision makers think about those trade-offs in future? |
| AB | Yes. Again, the testing approach is very dependent on what the strategy is and you'll be aware, and I think it's described nicely on the Ministry of Health's response that accuracy and accessibility, the most accurate tests were fundamental through the elimination phase because you had to find – if there was a case out there, you had to find it, and you had to find it as soon as possible and then be able to respond to it. And the big challenge was we couldn't necessarily rely on Rapid Antigen Test development to find every case just because their sensitivity is not as high as the PCR testing. So I think it's again being really – and we've learnt a lot about different testing modalities and at what point you can and should deploy them. I think one of the things we've learnt is a role that those Rapid Antigen Tests can play as part of the kind of non-lockdown type measures, restrictive measures, so using Rapid Antigen Tests for perhaps some workforces which we then moved to instead of requiring them to stay home or be part of a lockdown. Again, we know so much more about the role that these things play now than we knew pre-COVID, because this is the first pandemic where both PCR testing and Rapid Antigen Testing have been so widely available and made such a critical role. |
| AH | Do you think we got access to different modalities of testing early enough? If you could go back in time, would you do anything different in that space? |

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| AB | It's hard to say. I think there's a really good description of what happened, and why, in the Ministry's response and again, I read through it again yesterday just to remind myself of what decisions were made and why at that point in time and we were operating with what information we had. And also – and this goes to vaccine availability which I've alluded to as well – the whole issue of New Zealand and supply chains became such a critical issue and that affected access to PPE, vaccines and Rapid Antigen Tests and other testing modalities so these things are things that can be anticipated and planned for as well, but some of those rightly influenced the deployment, or the timing of deployment, of vaccines and the Rapid Antigen Tests. |
| AH | Thanks. I want to turn briefly to international matters. I think you've covered these largely so feel free to augment, but there was such an enormous level of international information and analysis coming out. Can you tell us how the Ministry processed all of that? You were given papers, so we are aware you had international scanning going on. Just talk us through how that happened and how it was processed and how it fed into your decision making. |
| AB | Yes, we were doing some of it on the public health side, that was our role. But a lot of the international information was being gathered through MFAT and through a range of other sources to feed directly into the Department of Prime Minister and Cabinet and the advice that the COVID – early on in the pandemic I could personally keep in touch with every published paper about COVID because it was a nascent, it was a new and novel virus. And so there was such a small body of work and then because it was such a small body of published literally, we used right from early on and then continued our key channels being part of the Five Eyes group of Director of Public Health counterparts. We were involved daily on the discussions with the Australians and they were fantastic actually and being inclusive with us and exchange of information was excellent. The Chief Science Advisor, Ian Town, the Prime Minister's Chief Science Advisor, Juliet Gerrard, were linking with their networks around the globe, especially early on. And then that set the pattern for how we maintained those networks as we went through the pandemic. As you can see from the Ministry of Health's response, by the time we got through 2020 into 2021 there was significant teams established just around each part of the response. We had contact tracing and testing, vaccine, the public health response, and so each of those teams was looking at what was happening internationally and including that in their parts of the advice that might be coming through, or informing public health risk assessments. So I guess a pattern established very early on and was then augmented as we went through. We also of course had a large |

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| | number of technical advisory committees and groups, the members of which were connected to their networks internationally and bringing information to the advice that those groups would be putting together and the matters they would be discussing, and then that information would come up into advice that would – in particular, I think by the time we got into 2020, there were two mainstreams of advice. One was around the response and the public health risk assessments and of course the vaccine, and I know you've talked to Chris James from Medsafe and others about all the mechanisms that were put in place to keep on top of what was emerging around vaccine safety and effectiveness globally through the networks that they had to keep us up to date with, to make sure our vaccine programme was responding to emerging knowledge and evidence. |
| AH | And yes we have, he was very helpful. That's confidential obviously. You talked about the Five Eyes. Are there countries that we regarded as comparative for us? Who were the main ones off the top of your head? |
| AB | We had quite a lot of interaction with Singapore as well. A lot of people were looking towards Taiwan to see what they were doing, another country of course, jurisdiction, and some commentators talking about the effectiveness of their response and so there was quite a lot information there. And also, because we were plugged into the WHO and our network there, we could see what was happening and if necessary get in contact with other countries. But they would be the main ones – the Five Eyes in terms of information exchange. Looking back, Singapore was a key informing jurisdiction as well. |
| AH | You mentioned WHO. Can you talk a bit about the consideration, recommendations and advice from WHO. How was that deployed in this context, in the COVID-19 context? In terms of consideration and our decision making. |
| AB | Obviously we looked to that WHO advice really carefully, especially early on in the pandemic when it was urgent and on technical matters we looked at technical advice around use of masks. However, we would also look at that advice in the context of New Zealand's situation and our response. A particularly important example here is the WHO, consistent with the International Health Regulations, was advising countries for quite some time not to take measures at the border or to restrict travel. And clearly many countries, including New Zealand – and New Zealand in fact from very early in February restricted travel from people who were coming from or who had transferred from China, in a way contrary to WHO advice. So yes, we looked carefully to the WHO advice. Staff would tune into their technical |

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| | briefings and their regular situation reports we would obviously read and it gave a really important part of the picture about what was happening globally, but neither we nor other countries just religiously followed their advice because it needed to be apposite to the New Zealand situation and certainly an elimination approach was not one that was part of WHO's advice. |
| AH | Before I invite my colleague Commissioner to ask any questions, I have a closing question for you and that is, overall, what do you think New Zealand needs to improve or do differently to be better prepared for the next pandemic – in 25 words or less. |
| AB | Expect that it could happen tomorrow. |
| AH | Yeah. |
| AH | It's quite disconcerting that idea, isn't it. One of the things that we've heard a lot about and we're thinking a lot about is system capability and capacity, and we've had one senior person say to us this was carried essentially be between 30 and 50 people who carried this heroic load and did heroic things. And clearly you were the forefront of that group. As we think about that, we're going to need capable people in our system to step up for next time. What do you think about that idea and how do we ensure we've got the human capability in the government system. |
| VC | Are you talking there wider than Health? |
| AH | Absolutely. But some health as well – I'm just thinking, as we think about the future and tomorrow's a terrifying date, looking at it that way because we know how time [inaudible 1:51:08], can you talk to us about that? |
| AB | In 25 words or less? [Laughter] |
| AH | Actually, seriously – as many words as you like. |
| AB | I've given this a bit of thought. A key lesson for me through the pandemic is if you look at the effectiveness of the responses of different countries. And looking at effectiveness in terms of those really key outcomes, its economic impact, pretty important ones. What was clear was, the thing that seemed to make the biggest difference was really good leadership, clear leadership, and really good decision making processes. And our plans for future pandemics don't tend to – they put in place structures, but they don't tend to focus on leadership, what's the leadership structure and mechanism and what are the decision making processes. So I think my main suggestion is we should test those things with a whole |

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| | range of scenarios, not just public health ones, and I think this is one of the broader lessons for government about responding to crises. It's not about the plan, it's about how you respond at the time. And to have a wider group of people who are trained in exercising regularly micro-simulations, what it looks like, and to learn how to respond and what sort of process is going to be in place, how are decisions going to be made, I think it's those process things that we need to focus more on in terms of our preparation for the future, and that is something you can – yes I had done some media training and some media work before COVID, but I didn't do 300 standups in preparation. But putting a dozen people through doing three standups would be pretty helpful. So I think it's about really thinking about the decision making process and how that leadership can be shared. At the end of the day there may well still be 30 or 50 people next time that carry the weight because they find themselves in those key roles at that time in history and Churchill was the Prime Minister right through the Second World War. And it didn't always go well. |
| AH | Well I have completed the questions that I have. I'll make a couple of comments at the end. Before I do that, I'm going to open to Commissioner Kavanagh – any questions? |
| JK | I don't have so much a question as things that I'm concerned about, and I wondered if you had reflections about. There's been a study undertaken by Lisa Meehan and her cohort, their colleagues at AUT. Using the IDI and matching up the vaccination status of parents with the immunisation uptake, the four year old immunisation of their children, and there is a clear link in that, and I am concerned about the impact of COVID in the way in which parents might behave with their children. Having just become a grandmother myself, and I'm interested in the work that Health needs to do now and in fact Education needs to do now, to actually build our resilience and our levels of vaccination, our acceptance of vaccination, for the future. So do you have any lessons for the Ministry of Health now around vaccines and vaccine hesitancy? |
| AB | I think there's nothing I would say that the Ministry probably doesn't know already and Te Whatu Ora Health New Zealand as well. I guess two quick comments. One is, it's probably not surprising. COVID was a hugely disruptive event in New Zealand and globally and this impact has been seen globally, it's not unique to New Zealand and of course many childhood vaccination programmes were disrupted. In just about every country this happened.<br>The second comment I would make is it will swing back. The tide goes out and it comes back in, and our lesson from the late 90s through to 2015 was it takes a sustained effort, a meticulous approach, but if you put the basics in place and just keep at it and monitor and |

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| | celebrate success and make sure there are, as we went through COVID, that you've got messages and messages and access for a range of different population groups, you can get those vaccination rates back up again. So it's definitely not a hopeless cause and I think the latest Te Whatu Ora data showed we're now at 80% and it's climbing and it will be slow, but it's definitely possible. |
| JK | Thank you, that's helpful for the future. |
| AH | Mr Chairman. |
| GI | Good morning, Sir Ashley. I've got a few questions. Are we okay for time? |
| AH | We've got about five – are you happy to go slightly over, Sir Ashley? |
| AB | Sure. |
| AH | Yeah. |
| GI | You mentioned the lockdown in the north and low coverage for some and your response to that was we should be enabling the providers. What would that look like in practice? |
| AB | Thank you, yes, and good morning. I should say we were enabling the providers. If I recall the point I was making, we couldn't start early enough with really gearing those providers up and resourcing them, because for many of those groups it required four, five, six conversations – interactions – until they were confident enough to take the vaccine. So I think my main comment would be trying to bring that forward as much as possible. |
| GI | Thank you. |
| AB | It was certainly on our radar but a lesson could be right at the start, if you think next month's the right time, start today. |
| GI | Does that mean that we really need to have a network in place where we recognise who the relevant community providers would be, and have a warmed up system and able to get those networks moving in an emergency? |
| AB | Yes, that would make sense and we can build on what happened during COVID which was an extension of the workforce who could vaccinate, which was done all in very quick timing, was profoundly impactful and also we've seen a shift – it's been sustained in the system, for example, particularly towards pharmacies being much more a setting where a wider range of vaccinations can be undertaken, so our system's already warmer on an ongoing basis. I think the key provider group I would be most interested in seeing sustained and having a |

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| | sustained level of capability and capacity would be our Māori and Pacific providers. Not just for the vaccination – they were critical in terms of the response as well and particularly accessing those more marginalised communities who are often the ones where the infections happened. A good example is during that longer lockdown in 2021, the community in the Waikato of drug users who were often mobile and no fixed abode, and those providers were excellent at working with the public health units to find those people, build trust and get them either for testing or to volunteer potential contacts. So that's a really critical path of the system that we need to – for many other reasons but including for pandemic planning and response. |
| GI | You mentioned the Defence Force and the potential to use some of their – I think you described it as redundancy – the resources that they could then contribute more meaningfully in the future. Can you just unpack that a little for us? |
| AB | Yes. I should say it's a personal idea I've had. I've shared it with a few people. I think the key point here is Defence Force medics are actually not legislatively allowed to treat non-Defence Force personnel. So that's something that may be worth looking at from a regulatory perspective. But the other is, it's a very small workforce. I think there are less than 30 nurses across all three arms of the Defence Force across Aotearoa. A lot of people don't know that, but you could imagine either through the regular Force or the reserve Force, you might be able to put incentives in place or create more opportunity to expand that workforce, so even if that nursing workforce was one or two hundred people – not all of them need to be regular Force – that could be a really useful capacity that could be deployed more effectively and during peacetime could add to New Zealand's soft power projection, particularly into the Pacific. |
| GI | Thank you. As at the beginning our period of inquiry, the effective legislation under which you were operating and under which Government was operating, was of course the COVID Response Act of 2020. That was stood up in urgent circumstances back in 2020. And it operated by giving discretionary power to you and Ministers to make various orders, of which a large number were made. And that large number of orders was quite difficult for the ordinary population to follow. Do you agree with that? |
| AB | It would be hard to disagree. I've got a bound volume of all the orders and there are, as you say, an extensive number of them. So yes, so saying, I think the way to communicate the intent of the orders was through the regular briefings that we did to the public, and so it |

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| | wasn't that the orders were just agreed upon and then there was an expectation the public would know what was in them, so it was the complementary communication strategy that I think we should point to in terms of the way the public was brought up to speed about what the orders contained and what they meant and what the implications were for them. |
| GI | If we go back to 2016, I think you told us what your position was at that time. Could you just repeat that for me please? |
| AB | Between 2015 and during 2018 I was Chief Executive at Hutt Valley District Health Board. |
| GI | Did that involve you in the Health Amendment Act 2016? |
| AB | No. No, because I wasn't working at the Ministry of Health at that time. |
| GI | Right. Are you familiar with the amendments to the Health Act that were made in 2016? |
| AB | I don't recall – not off the top of my head. |
| GI | The background to that I think was that there had been infectious diseases like Ebola and SARS and MERS back in the earlier period and this was supposed to be New Zealand's response. But it seems that this wasn't an effective framework for dealing with COVID because we had to largely replace it with the COVID Response Act 2020. Do you have a perspective on that at all? |
| AB | Not specifically. None of those other diseases which I think you were saying what inspired the changes in 2016 to the Health Act and, again, I'm not sure exactly what the changes were. None of those were global pandemics and COVID of course rapidly evolved into a pandemic so required a different response from SARS, MERS and Ebola. |
| AH | But Taiwan and Singapore and perhaps other countries had learned some lessons from SARS, MERS and Ebola which put them, I think, in a better position than us when COVID came into play? |
| AB | I'll take that as a statement, not a question, if you don't mind. |
| VC | Sorry, but there's an awful lot in that statement. In a better position in what way? |
| GI | Just generally, it seems that Taiwan and Singapore were a little better prepared than us for an epidemic we'll call it rather than a pandemic, but in their own countries they seemed to have a bit more preparation done. Is that an observation you'd agree with? |

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| AB | What I would agree with is that, yes, Taiwan and Singapore had had experience, in particular, of SARS Co-Variant 1 in the early 2000s, and as a response had implemented specific measures in their jurisdictions. That put them certainly in a better position at the start at the pandemic. Better, I would say, than every other country, including New Zealand. That didn't mean that New Zealand like other countries hadn't learnt lessons from MERS, SARS, Ebola and of course the 2009 influenza pandemic as well, and it was off the back of that pandemic that saw us updating our pandemic influenza plan that was revised in 2017, so again, I'm still not sure what the changes to the Health Act were in 2016 but part of that response, that evolving capability and capacity, was the revision of the pandemic influenza plan in 2017. |
| GI | Would it be fair to say that the plans that we had before the outbreak of COVID were less than optimal in terms of dealing with the Coronavirus that eventually arrived on our shores? |
| AB | Would it be fair to say? I think you could say that although, again, New Zealand's pandemic influenza plan is similar to those that many other countries had and indeed the WHO had – and this was the challenge of the COVID pandemic was that the expectation was that any global pandemic would most likely be an influenza virus and hence that had influenced the planning. What became apparent of course immediately was, it wasn't an influenza virus and it wasn't behaving like an influenza virus so we had to, from very early on in the pandemic, adapt our response as every other country did as well. |
| GI | So would it be correct to say that although we didn't have a plan that was well suited for the outbreak of COVID SARS 2, neither did any other country, but other countries were better prepared than us in relation to this particular virus? |
| AB | It would be correct to say that and this is one of the key lessons and goes to my point about what it is we should practise and plan for, and what we learnt from COVID was the importance of being able to be very agile and adaptable and have really good decision making and rapid decision making mechanisms in place because even if the next virus, the next pandemic, is an influence virus, it may behave quite differently from the way that influenza viruses behaved in previous influenza pandemics. And also our understanding and knowledge of the possible tools and responses and our ability to access vaccines will be very different from what has been the case in previous influenza pandemics. |
| GI | Do you accept that part of the planning for the future involves having data around communities, people movements and that sort of thing? |

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| AB | Absolutely, and this is where modelling can be of value. And also a small plug here for the organisation I'm now working for, ESR, which has developed a digital twin of the New Zealand population which you could use with other tools to actually – because it's essentially [inaudible 2:11:32] New Zealand population and you could model these things and use that amongst other tools to support a response in real time. |
| VC | Sorry, can I just interrupt there, Mr Chair. You asked two elements to that. Planning for the future involves good data around communities and people movement etc? I'm not sure you picked up that second thing about data about how people move. |
| AB | Yes. I tried to in my response. So yes, you need good data and so tools like a digital twin of the population can – not just based on the data from the IDI and other sources, but then you can model actually different movements and you could put into that traffic movements and people movements of course which we've got quite good information on now because we all carry a trackable device with us everywhere. |
| GI | Is it fair to say that our resources were quite limited and had to be built up as we went during the COVID period? |
| AB | Actually I think data was where New Zealand was quite well off. Our health system has got the tremendous advantage of having a national health index, so a unique identifier for everybody, so an ability to link data and, as I mentioned, we also had the IDI. So data was probably not an area of where we had a gap and in fact it was that data that allowed us then to build the modelling capability and capacity that was very helpful in terms of informing decisions. |
| GI | We've heard that there were deficiencies in some of the data that they needed to carry out the modelling. Are you aware of what areas that would be in? |
| AB | No, I'm not aware. |
| GI | But presumably they would be outside the Ministry of Health's system if the Ministry of Health had detailed databases? |
| VC | Grant, at this point, if you've got a list of deficiencies, it might be clearer to specify those for Sir Ashley. |
| GI | I think Sir Ashley has answered the question. He's told us that the Ministry of Health had detailed data on the health system and it's probably outside his area of expertise to say what |

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| | other data might have been available or not available, so I'm happy not to dispute that further. |
| VC | Okay. |
| GI | Now you talked about listening and communication and expressed the view that they were in effect two sides of the same coin. Have I got that right? |
| AB | Yes, I think the phrase I used was communication's a two-way exercise, it starts with listening. |
| GI | Now do you think that the Government had appropriate structural mechanisms in place to listen to what was happening in the community during the times when things were most stressful? |
| AB | I couldn't speak to all the mechanisms or processes that might have been in place right across Government. I do know there were a lot of channels for information to come in through different agencies' interactions with a range of groups, for example, iwi, Pacific communities and on the Health side of course we had regular interactions with the full range of health providers, so there were mechanisms and I think of listening, also in a bit of a generic sense in the sense of gathering information, both of course here in New Zealand and also internationally, so making sure that information is gathered and then put together to help inform decisions. |
| GI | How could we improve the listening process in terms of how government hears from the community? |
| AB | I don't have any more detailed ideas other than the suggestion I offered earlier on which is having priority mechanisms and frameworks in place that are seen to be a part of the preparation and are ready to activate once we're in that situation, so prior thought and planning and a systematic approach to this could be helpful. |
| GI | In relation to vaccine safety, do you accept that there are risks in relation to vaccines such as pericarditis and myocarditis that produce allergic responses? |
| AB | Yes, and this is of course the same with any vaccine and indeed any medicine or drug, prescription or otherwise. |

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| GI | One answer to the critics of vaccination in relation to those issues might be that the risks of getting the virus are actually greater in those areas than having the vaccine. Is that the view that you would concur with? |
| AB | I think it's a very important part of providing the information to the public, is putting vaccine risks in context. And you've raised myocarditis, that's a good example and one of the challenges of identifying vaccine related myocarditis, not so much in New Zealand but in other countries that of course it was a side effect or a result of COVID-19 infection per se and in fact the studies that were being done at the time we were rolling the vaccine programme showed that the risk of myocarditis was about eight times higher than the risk – if you were infected with COVID-19, eight times higher than if you had been vaccinated and it was a side effect of the vaccine. So an important part of the overall information package to try and explain to people the relative risks of being vaccinated or not being vaccinated and if they were … |
| GI | If you were in a situation with you as a medical practitioner, talking to a client who was concerned about vaccination, presumably you would try to make sure that the person had enough information to provide informed consent about accepting the vaccine. |
| AB | Yes, of course. That's an obligation on a health practitioner. |
| GI | And if we look at the relationship between government as a whole and the nation as a whole, is there any real difference in relation to the obligation to provide information that enables the country to give informed consent, or those people who are looking at getting vaccination? In other words, is there an analogy to be drawn between the doctor/client relationship and the government/country relationship? |
| AB | I hadn't really thought about that so if you wouldn't mind, I'd need to give that some more thought, 'cos I think they are distinct things. I've made a career as a public health physician rather than someone who has an interaction on a daily basis with individual patients and there is a difference, but I haven't thought about the proposition you've put forward, so I'd need to give that some more thought. |
| GI | Your role as a Director-General Health advising the country, would it have been part of your efforts to make sure that the country was well advised about the side effects and risks of being vaccinated? |

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| AB | Do you mean me specifically or me ensuring that that information was available to those who were delivering the programme so that it could be shared in that one-on-one clinical interaction? |
| GI | The latter. |
| AB | Yes, that was an important part of our vaccination programme, to ensure that there was information and resources available for those delivering the vaccines so that they could have those conversations, and that those resources were updated as new information came to light, for example, around the incidence of myocarditis as a side effect. |
| GI | You may think I'm getting you to state the obvious, but there's a reason for it which is that I have to deal with some other groups that have views which are in opposition to those that were expressed by Government at the time, so that's really why I'm getting you to just go over these basic points. One of the points is that you've said the answer to mis-information, at least in part, is correct information clearly stated and clearly communicated. Is that your position? |
| AB | Yes, it is. |
| GI | So in the future, would you recommend a system that more clearly and accurately, with more availability, gives advice to the public about particular risks and side effects of vaccines? |
| AB | The implication to your question is that the information provided during COVID was not clear or accurate, which I don't agree with. I think there was a sustained effort to provide information and that was a key part of both the response and the vaccination programme. |
| GI | But I think you'd accept that in some parts of the community those messages weren't clearly understood always? |
| AB | That may be so, however, I don't think that was necessarily because the information wasn't available. It was a sustained effort to ensure that information was disseminated through a whole range of channels to different community groups. |
| GI | Perhaps to put this more specifically, would it be helpful in future for government – perhaps Ministry of Health – to have a dedicated website which provides detailed scientific advice on how vaccines work, the risks etc. |

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| AB | Off the top of my head I would say that the Medsafe website already provides a high degree of detail about those matters, not just for vaccines, but for all pharmaceuticals, or provides links through to where that detailed information could be. I think the key issue here is that to reach as many people as possible requires a combination of the right messages, the right channels and the right messengers. And that's something that was a key focus for our communication approach through both the response and the vaccination programme. |
| GI | Do you think that system of communication could be improved and if so, how so? |
| AB | Well there's always room for improvement and I guess that's the purpose of the Inquiry, isn't it, to find out from a range of different perspectives how that aspect of the COVID response and other aspects of the COVID response could be improved. |
| GI | So I'm now going to ask you some questions that might seem a little bizarre, but it's for the reason that I explained earlier, that I have to later deal with some dissenting views. The accusation has been made that you and the Government were part of an international conspiracy in relation to the COVID response. What do you say about that? |
| AB | No. |
| VC | I think that's enough. |
| GI | And can I ask you this. Did you ever have any suspicions that our Government or any people involved in the leadership of the COVID response were involved in any way in a conspiracy of the kind that's been alleged? |
| AB | No. Never for one moment did I think that. |
| GI | Right. The reason for me asking that hopefully will be obvious, but just finally then, I should ask you this. Tony Blakely. Do you recall having any interactions with him during the 2021 period? |
| AB | I may well have. Tony and I did our public health training together so we've been colleagues for a long time and we may have had some interaction during 2021, but I couldn't say so with confidence. |
| GI | In that period, he expressed the view publicly via news media that it was unnecessary to get to the 90% vaccination target before going out of lockdowns. Do you recall that at all? |
| AB | I don't recall that. I recall a range of different views from a range of commentators, some of them even New Zealand based, on what was an appropriate level. |

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| GI | He's drawn attention to the fact that then Victoria and I think it was New South Wales, they terminated lockdown at a much lower vaccination level than the 90%, without any apparent increase in vaccination rates. Do you recall that issue? |
| AB | Sorry, increase in vaccination rates or increase in death rates? |
| GI | Increase in infection rates. |
| AB | Infection rates. Look, I don't recall that specifically. I've pointed a number of times to the Cabinet paper from early October, we were looking at what was happening in a range of jurisdictions and most importantly we were thinking about what the implications might be for Aotearoa New Zealand at that time and with our population and with our vaccination rates, including the distribution of vaccination rates across the population. |
| GI | Is it fair to say that the decision to stay in lockdown was largely influenced by the lower vaccination rates in the Māori and Pasifika population? |
| AB | Is it fair to say. Is it fair to say. I think, again, just pointing to the Cabinet paper, it's really clear that there were a full range of considerations to inform each decision about changes in levels continuing or not continuing lockdowns in different places, so the vaccination rates and their distribution in the population was definitely one input, but it was not a singular input. |
| GI | If there's one recommendation that you would like us to make for the future, what would that be? |
| AB | I think similar to what I said to Anthony earlier on, we should start today, start tomorrow, there is a risk of a new pandemic any time and the lessons, we should be incorporating and testing the lessons and what we've learnt, regularly. |
| GI | Thank you, Sir Ashley. That's my questions. |
| AB | Thank you, Chair. |
| AH | Well Sir Ashley, thank you so much for your time today and we really appreciate the information and answers that you've given and just would like to conclude as our began. You were called to serve at a particular time and your contribution was really extraordinary and we are grateful for that, so thank you. |
| AB | Thanks, appreciate it. Thanks very much. Thank you, Chair, and all the very best with your work. It's a big task and I appreciate the discussion today. |

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| AH | Thank you very much, so the interview is at an end. |
| **End of interview** | |