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

PHASE 2

RESPONSES TO QUESTIONS FOR HON ANDREW LITTLE
4 August 2025

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Context

i. The Terms of Reference for Phase 2 of the NZ Royal Commission COVID-19 Lessons Learned|Te Tira Ārai Urutā (**Inquiry**) require the Inquiry to review key decisions taken by Government in New Zealand's response to COVID-19 during 2021 and 2022.

ii. Key decisions in scope of the Inquiry are limited to decisions regarding the matters listed in clause 4(1) of the Inquiry Terms of Reference. A key decision is further defined in clause 4(2) as "a decision that has a potential or actual significant impact on large numbers of people or groups of people, or that has a significant cost at a national or regional level".

iii. By letter dated 4 July 2025 the Inquiry invited Hon Andrew Little to respond to fourteen questions (**the questions**) directed at his approach to decision-making in the pandemic response and the information and other expertise drawn upon. Responses to the questions were to be in lieu of a private interview.

iv. In a further letter dated 18 July 2025 Counsel Assisting the Inquiry provided clarifications to some of the questions.

v. The Inquiry provided a bundle of documents for the purpose of responding to the questions. Most of the documents are publicly available. A small number of non-public documents were provided in confidence. The index to the documents identifies specific documents relevant to the questions for Hon Andrew Little.

vi. The responses of Hon Andrew Little to the questions, as clarified on 18 July 2025, follow. The responses are provided on the understanding they are confidential to the Inquiry, being provided in lieu of a private interview.

Systems for receiving and managing advice

Question 1

What was the scope of your role as the Minister of Health in 2021-2022 and, in that capacity, what were your responsibilities in relation to the COVID-19 pandemic?

Response to Question 1

1.1. I was Minister of Health from 6 November 2020 until 1 February 2023.

1.2. As Minister of Health I was responsible for the Health portfolio. In general terms, I was responsible for the health system overall. However, at this time with a specific portfolio dedicated to the Covid-19 response, the scope of my role as Minister of Health was modified accordingly. Within the Health portfolio a number of areas were delegated to Associate Ministers of Health.

1.3. In the 2021-2022 period Hon Dr Ayesha Verrall was Associate Minister of Health with delegations in respect of specified matters relating to public health, women's health, natural health products, rheumatic fever, and specific population groups. Hon Aupito William Sio was Associate Minister of Health (Pacific Peoples) with delegated responsibility for certain matters in the Health portfolio relating to Pacific peoples. Hon Peeni Henare was Associate Minister of Health (Maōri Health) with delegated responsibility for certain matters in the Health portfolio relating to Maōri. All three Associate Ministers of Health were to work closely with and play a coordinating role with the Minister of Health and other Associate Ministers of Health on the COVID-19 response under the leadership of the Minister for COVID-19 Response. For more detail see the Schedule of Responsibilities Delegated to Associate Ministers and Parliamentary Under-Secretaries, 3 December 2020.

1.4. The Ministry of Health was responsible for overall system leadership, including policy and regulation, high-level pandemic preparation, and monitoring. The Health Infrastructure Unit within the Ministry was a reasonably new development and its purpose was to better coordinate capital asset management across the health system. In relation to the COVID-19 pandemic my responsibilities were mainly focussed on the overall capacity of the health system, including co-ordination across the 20 District Health Boards and 12 Public Health Units and the roll-out of the vaccine programme.

Question 2

Other than the Ministry of Health, what sources of information and advice did you rely on in making decisions?

Response to Question 2

2.1 Most of the advice I relied on in making decisions in my capacity as Minister of Health was sourced from the Ministry of Health as well as other parts of the public health administrative structure such as the Cancer Control Agency, the Mental health and Wellbeing Commission and Pharmac. Working or advisory groups were established for chronic system issues which were emerging. The New Zealand Nurses Organisation had raised with me their concern about the adequacy of the Care Capacity Demand Management (CCDM) system for planning and managing the nursing staffing complement and so an independent review of that system was commissioned and reported in February 2022. As waiting lists for planned care grew as a consequence of hospital restrictions throughout 2020 and 2021, a working group was established to assemble advice on measures to more effectively manage the growing waiting list and increasing waiting times for this care.

2.2 A range of advice was received by ministers at Cabinet level. Such advice is referenced in the relevant Cabinet papers and in the Phase 1 *Lessons from COVID-19 to prepare Aotearoa New Zealand for a future pandemic*, Main Report, November 2024 (**Phase 1 Report**). I cannot recall any other sources of information not already referred to in the Phase 1 Report or the Cabinet papers.

2.3 The health sector has a significant number of advocacy and interest groups and a lot of scholarship is generated about system issues and challenges. I was in frequent contact with many advocacy organisations and received much information from them.

Question 3

How did Cabinet weigh Health advice against other advice through the pandemic?

Response to Question 3

3.1. The advice given to Cabinet is referred to in the Cabinet papers. The weight given to different advice is generally reflected in the Minute of the relevant decisions. The response to what was regarded then as the single biggest nationwide public health threat for more than a hundred years was the priority issue the government of the day faced from the beginning of 2020

and the government made decisions on the health response on the basis of the full range of information and advice available to it, all of it given careful consideration.

3.2. Consistent with Cabinet Collective responsibility it is not appropriate for me to comment on the deliberations of Cabinet.

Question 4

How did your role as Minister of Health overlap, and work alongside, that of the Associate Minister of Health and Minister for the COVID-19 Response?

Response to Question 4

4.1 As noted in response to Question 1, there were three Associate Ministers of Health in the 2021-2022 period. I have summarised the scope of their respective delegations in response to that question. The Minister for the COVID-19 Response was responsible for overseeing managed isolation, border defences and the health response, including testing and contact tracing.

4.2 My role was to ensure the health system, principally the District Health Boards, had the means and capacity to support the response. I was in regular contact with board chairs through on-line meetings to ensure their challenges and needs were being heard. This was particularly in relation to the roll-out of the vaccination programme which entailed a diversion of resources from hospital functions to community functions. There was a discrete programme directed at supporting community health providers, especially those dealing with parts of communities regarded as marginal or hard to reach. This meant liaising with organisations based in Māori and Pacific communities. Other ministries and departments, mainly the Ministry for Social Development, Te Arawhiti and Te Puni Kōkiri, along with their Ministers, were part of this endeavour.

4.3 As Minister of Health, I was involved in most of the Covid-19 response-specific officials meetings (there were many meetings held with a high rate of frequency held almost entirely on-line) and was able to share the information and insights from my other meetings with those officials meetings. The Covid-19 response would often come up in my regular weekly

Health officials meeting which was attended by all Associate Health Ministers. Decisions made under a Cabinet delegation or under a statutory authority were generally made by round-robin circulation of a proposed decision and supporting information and advice with questions and queries answered through officials.

Decisions affecting the health system

Question 5

We understand that one of the key public health goals of the Government during the pandemic was minimising the impact to the hospital system. Was that goal met during your time as Minister of Health? Please explain why or why not.

Response to Question 5

5.1 In responding to question 5, I note it is unclear what "key decision" relevant to the Inquiry Terms of Reference is to be addressed in my response. I proceed on the assumption the question is directed to the effectiveness of the imposition of lockdowns and the approval of vaccines during 2021-2022 in order to achieve the goal referred to in the question.

5.2 Based on the known epidemiological properties of the Covid-19 virus at the outset of the response in early 2020, a critical public health goal of the Government was to prevent the health system from being overwhelmed. As I recall, this was based on an assessment that with a comparatively large elder population as well as other vulnerable populations, primary and secondary care services would not cope with the health effects of an outbreak. It was expected that an outbreak would cause a significant number of people to become severely unwell with many requiring a high degree of medical intervention. Widespread infection would also affect the health workforce and the aim was to avoid having a diminished workforce having to respond to a likely significant increase in demand for health services.

5.3 Preventing the health system from being overwhelmed is not the same as 'minimising' the impact on the health system, which is the term referred to in question 5. It was inevitable that there would be significant impacts on the health system and we had seen this happening in other countries. Our

objective was to control and manage these impacts so the system could largely continue to function, including for the range of non-Covid conditions which still needed to be attended to.

5.4 In my time as Minister of Health the goal of preventing the health system from being overwhelmed was met – the performance of our hospital system compared favourably with that of hospitals in other countries. The reasons for this are noted in the Phase 1 Report and include the public health and infection control measures activated during the pandemic as part of the elimination strategy until late 2021 and the population's high levels of immunity from vaccination by the time COVID-19 transmission became widespread (Phase 1 Report pp 212-214). I have nothing to add to the Inquiry's conclusions in this regard.

5.5 By the beginning of 2022 when the vaccination programme had achieved a desired level of community immunity and as steps were being taken to relax and reduce health measures, including opening the border, planning was undertaken for the 2022 winter cold and flu season. It was expected that the combination of the ongoing presence of Covid-19 as well as strains of flu and respiratory conditions from overseas which New Zealand had not been exposed to in the previous two calendar years would cause a heightened incidence of these health effects and the health system would come under strain. That is what happened, and to a greater degree than had been expected.

Question 6

We have seen in the documentation indications that the health system was not equipped to manage significant numbers of COVID-19 infections, and that there were no substantial changes to ICU capacity until mid-2022. This appeared to be a reason for maintaining the Auckland lockdown and slowing entry into the COVID-19 Protection Framework (CPF).

a. Was the health system adequately funded to respond to a pandemic when you took over the portfolio? Please explain your answer.

b. What steps were taken to improve the health system's capacity in 2021?

c. What progress had been made by October 2021, and what progress was made thereafter?

d. With the various investment decisions made while in the portfolio, do you think the system is better or worse placed to respond now? Please explain your answer.

e. What advice was provided to you on these issues?

Clarification
On 18 July 2025 the Inquiry provided the following clarification of this question:

> *Clause 5 of the TOR directs us to provide recommendations on considerations that should be taken into account in future decisions to best prepare New Zealand to respond to any further pandemics. If Mr Little has views on the extent to which shortcomings in the health system or funding and support for community providers at the time of the pandemic have been remedied by subsequent spending or policies, then these are relevant to what we recommend, or commend, as contributing to better preparedness….*
>
> *The key documentation has already been provided on the USB and comprises the DPMC briefing of 10 October 2021. We also refer to Phase 1 report, Part 2, p 198 regarding ICU capacity:*
>
> *"While these reports demonstrate significant effort and at least some potential to surge capacity to care for ventilated patients, the Inquiry saw no evidence of a sustained ability to increase this capacity during the first 18 months of the pandemic response. According to the Ministry of Health, despite the early availability of funding, ICU capacity in July 2022 was similar to that at the start of 2020, with national numbers remaining the same at around 260. In November 2021, Cabinet established a contingency fund to increase ICU capacity, and in February 2022 the Ministry of Health sought to draw on it to increase critical care bed numbers to around 345 beds (including staffing). The Ministry advised us that – by January 2024 – funded ICU capacity was 312."*

Response to Question 6

6. In responding to question 6, I note it is unclear what "key decision" relevant to the Inquiry Terms of Reference is to be addressed in my response. I proceed on the assumption this links to the decision to maintain the Auckland Lockdown and respond to this question on the assumption it is limited to funding required to ensure the system is not overwhelmed as a result of a pandemic, rather than

funding for the health system generally.

a. As noted by the Inquiry in the Phase 1 Report, the state of healthcare infrastructure in general, and hospital facilities in particular, were, in many instances, in a poor state even before the arrival of COVID-19 and, despite its strengths, the health and disability system was already facing multiple pressures going into the pandemic. As noted in the Phase 1 Report, "few health systems were equipped to cope with such an emergency, regardless of their level of resourcing." (See Phase 1 Report, p 183, and p 195). In assessing whether or not a health system, especially a predominantly public health system, is adequately funded, whether for business as usual or for responding to an unpredictable large-scale public health event, it is necessary to know what an effectively resourced system looks like, and in New Zealand's case for the peculiarities of our population. Without that, we do not know what the underlying systemic gap is, much less the gap in dealing with a major unforeseen event. Technology is rapidly changing treatments that are available and modes of delivery, as well as expectations by patients and their families about what they should get from the health system. On reflection, I consider that after years of applying the principles of new public management and driving efficiency across the public sector, a totally legitimate and important objective generally, it has led, in the public health system, to a lack of redundancy, or spare capacity, which I would have thought is vital for a system that needs to be able to cope with unpredictable surges in demand.

b. The question implies that improvements in capacity in the system can be achieved in short order. They cannot. It is important that reflections on the way the system operates are grounded in reality. The two biggest determinants of capacity are physical infrastructure and workforce. Replacing obsolete infrastructure or adding new infrastructure takes years as projects go through the multi-stage business case process even before a shovel enters the ground. Adding workforce is achieved through either creating our own, which, depending on the nature of the health professional, takes anything from six years to fifteen years for a competent new entrant,

or importing them if they are available at the rates of remuneration we offer. Senior clinicians can take between one and two years from the time recruitment commences to be in place, longer if they have an overseas qualification that needs to be validated. There is a worldwide shortage of health professionals. Steps taken to improve the health system's capacity in 2021 included, to the best of my recollection, reviewing the CCDM system to ensure our nursing staff complement was consistent with need, continuing investment in new and upgraded infrastructure including the $100 million investment in additional ICU and HDU capacity (note that this included a programme to train more ICU nurses and was to result in an increase of $140 million a year in operating costs once fully implemented). The ongoing roll-out of the 2019 Budget mental health and addiction investment meant that by the end of 2022, there were an additional 1100 primary care mental health and addiction roles that did not exist before 2020. Further investment was also made expanding the Mana Ake programme into five more regions. Programmes were funded to support more clinical psychologists and for trainee GPs to be supervised in a primary care setting. In Budget 2022, provision was made for additional ambulances and ambulance personnel.

c. The DPMC briefing dated 10 October 2021 (**DPMC briefing**) to which I have been referred is an update on work underway to support the development of a new domestic response framework for a highly vaccinated New Zealand. The DMPC briefing notes that while the Ministry of Health and DHBs had a co-ordinated programme of work underway, the health system was not at that time ready to handle more cases or more hospitalisations on a sustainable basis and the Ministry of Health was advocating for the timing of transition to a new framework to be conditional on health system readiness (DPMC Briefing at [8] and [25]). To the best of my recollection, the referenced programme of work that was underway at the time included preparing a funding bid for additional ICU capacity and working with primary care on resource needs. In 2022, approval was given for a significant investment in greater ICU and HDU capacity, including workforce measures.

d. I am not in a position to express a view on the extent to which shortcomings

in the health system or funding and support for community providers at the time of the pandemic have been remedied by subsequent spending or policies without the benefit of current knowledge of the system as I would have had while a serving Minister. I am aware that some decisions on physical infrastructure have been deferred but any other comment by me would be speculative.

e. Advice was provided to me on all of these issues. That advice was in the context of the range of other advice I received as Minister of Health, all requiring prioritisation in accordance with the range of short, medium and long term needs evident at the time. Decisions requiring additional resourcing are not confined to the Minister of Health alone and such decisions are mediated through the range of government processes which seek to allocate finite resources across the range of expressed needs.

Question 7

Under our Terms of Reference, we must assess what decision-makers were advised about the social and economic impacts of their decisions.

a. What advice did you seek and/or receive about the long- and short-term social and economic impacts, including to wait-lists and mental health, of delays to treatment caused by prioritising the COVID-19 response over other treatments?

b. What effects did you expect to see?

c. In particular, what advice did you receive about the long-term effects on the health system, and on the health of New Zealanders, of delays to treatment caused by the lockdown in August-December 2021?

d. What steps were taken to try to mitigate these effects?

e. How or to what extent was this taken into consideration when Cabinet was making decisions about alert levels?

f. Did impacts continue after a business-as-usual approach to COVID-19 management was adopted? In what ways?

Response to Question 7

7. In responding to question 7, I note it is unclear what "key decision" relevant to the Inquiry Terms of Reference is to be addressed in my response. I proceed on the assumption this question seeks information as to advice on any social or economic disruption likely to be caused by the decisions regarding the imposition and maintenance of lockdowns in 2021-2022, specifically the national lockdown in August and September 2021 and the extended lockdown in Auckland and Northland in September 2021.

    a. As noted by the Inquiry in its Phase 1 Report, Aotearoa New Zealand's health and disability system was already facing multiple pressures going into the pandemic, and these were intensified due to the demands of responding to the pandemic (Phase 1 Report, p 183). In responding to the pandemic we were reliant on the best information available at the time and this information was necessarily imperfect. The Covid-19 virus posed a significant threat to many vulnerable communities and protecting those communities from that threat was a priority. It was expected that the infection prevention and control measures would slow down processes for health providers. Part of the effort to protect the system from being overwhelmed was to restrict planned care in order to minimise the risk of avoidable infection for patients and health workers. This was expected to increase waiting times for that care, and this was a short term trade-off to protect people and the health system. As for the impact on mental health, it was expected that the level of disruption to people's routines and normal living patterns would be upsetting, especially for young people who are reliant on socialisation with their peer group for healthy social and emotional development. Additional funding was provided in the Auckland region to support organisations dealing with youth mental health. As the response continued throughout 2021 and restrictions continued in Auckland to an extent not applying to the rest of the country, it became apparent levels of stress were increasing. As noted in the Phase 1 Report, people in the health system worked hard to find ways to continue to provide care without relying on face-to-face contact and the Inquiry's case study of cancer care showed that sector performed well when compared internationally (Phase 1 Report pp 207-211).

b. The effects I expected to see in the health system were the disruptions which were observed, namely to planned care as well as the extra effort required for primary care to provide care to patients.

c. I do not recall any specific advice about the effect on delays to treatment caused specifically by the measures taken between August and December 2021. In responding to the pandemic, there was never at any time a delineation between events, responses and effects attributed to a particular period. We were dealing with a highly contagious virus with different strains emerging within months of the last and each having different effects on average. The advent of vaccines enabled us to move from an elimination strategy to a management strategy, but unpredictable setbacks along the way caused us to consider the effects of each outbreak, the interventions necessary to deal with each effectively and the trade-offs associated with the measures decided on.

d. Chapter 5 of the Phase 1 Report contains detailed findings on the reprioritisation of primary care, routine screening, immunisations and hospital-based care. The levels of planned care changed over time for various reasons, as documented in the Phase 1 Report. I have already referred to the measures taken to address delays in planned care and the increased demand for mental health care for young people in Auckland.

e. Cabinet papers and Minutes of Cabinet decisions about alert levels record what advice was taken into consideration when Cabinet was making decisions about alert levels. By way of example only, the 20 August 2021 Cabinet Paper and minute included in the bundle of documents provided to me for the purpose of responding to the questions lists at paragraph [9] the eight factors Cabinet had previously agreed to guide decisions on the appropriate Alert Level settings for New Zealand. These factors included, among others, the Director-General's satisfaction on the capacity and capability of our public health system, including surveillance and contact tracing systems, and evidence of the effects of the measures on the economy and society more broadly. In relation to the former, the paper records the Director-General's advice that there was no evidence to indicate a lack of

confidence in the capacity of the health system and that there were seasonal pressures on the system with winter illnesses (at [20]). Advice on the economic impacts from alert levels is noted at [32]-[35] of the paper. Consistent with Cabinet Collective responsibility I do not comment on the deliberations of Cabinet.

f. Impacts continued for some time, even after a business as usual approach was adopted. The level of disruption was significant and it was expected it would take time for adjustment and adaptation following such disruption.

Question 8

We understand that community health providers were critical to aspects of the pandemic response such as the vaccine rollout.

a. What lessons can central government learn about working with these community providers?

b. How can community providers be supported and funded by governments in future to continue to play this role?

Clarification

On 18 July 2025 the Inquiry clarified in relation to this question:

> *Clause 5 of the TOR directs us to provide recommendations on considerations that should be taken into account in future decisions to best prepare New Zealand to respond to any further pandemics. If Mr Little has views on the extent to which shortcomings in the health system or funding and support for community providers at the time of the pandemic have been remedied by subsequent spending or policies, then these are relevant to what we recommend, or commend, as contributing to better preparedness….*

Response to Question 8

8. It is unclear how question 8 relates to the key decisions referred to in the Inquiry Terms of Reference as vaccine roll-out is not a key decision linked to the three specified aspects of use of vaccines (mandates, approval of specific vaccines and vaccine safety). I provide some responses below that may nevertheless be of assistance to the Inquiry by way of context.

a. Community organisations played a critical role in support of the vaccine roll-

out. They enabled information and advice to be taken into communities in ways that made it more accessible. There were organisations who deal with parts of the community living on the margins, and those organisations were instrumental in assisting the system to understand what was happening and how to work most effectively with those people. The health administration eventually learned that in order to work effectively with community organisations, high trust relationships had to be allowed to develop and tasks had to be delegated to those organisations.

b. It is important that there are community organisations able to respond at times such as the pandemic. Having that latent capacity is helpful. It is for those organisations to say what would best assist them but from a preparedness point of view, having organisations with a minimum level of capacity and a demonstrated ability to surge as needed is an important facility for future public health events.

Communication strategies

Question 9

The public-facing communication of health advice was often conveyed by and alongside Ministers, and we have heard from some people that this may have politicised health messaging.

a. What is your response to this?

b. What reflections do you have as to how well this worked, and/or how it might be improved in the future?

Clarification

On 18 July 2025 the Inquiry clarified in relation to this question:

> *Communication strategies are within scope because they are key decisions to tell/explain/explain in a particular way, or not do one of those things, which expert evidence suggests have had significant impacts on large numbers of people…*
>
> *The question is expressed generally, but we are referring here to the 1pm briefings attended by Ministers and Ministry of Health officials. Please also see linked news articles provided with regard to Question 10 below.*

Response to Question 9

9. Notwithstanding the clarification noted above, communication of health advice does not appear to be in scope of the Terms of Reference. It can be expected that different communities and groups will have different needs from, and responses to, communications. The Phase 1 Report includes a section on public information and communication (Phase 1 Report at 2.53, see also p 288 (targeted communications for older people), p 340 (engagement with community providers regarding vaccine communications) and findings at p 354). In any event, the pandemic was a singularly critical event for the nation and the world. It dominated public policy and public financial decision-making for many months. It is inevitable that elected leaders were going to be part of the communications effort in order to be accountable for the decisions which were taken by them. It was important to have scientific and medical information about the public health event and in view of the fact that some of the most challenging decisions were about restrictions on people's movements and requirements to take prevention measures, such as wearing masks, keeping distances and vaccine mandates, it was important those decisions were attributable to elected leaders.

Question 10

We have heard that science speaks in terms of "probabilities" but some pandemic messaging was expressed in "absolutes" (e.g. "the vaccine is safe and effective" as opposed to "the vaccine meets safety standards and the benefits outweigh the risks"). How did you balance explaining the uncertainty that is inherent in some aspects of science with the need for clarity when communicating with the public?

Clarification

On 18 July 2025 the Inquiry provided links to examples of publicly available examples of "safe and effective" messaging and clarified in relation to this question:

> *This question is again expressed generally and we do not ask Mr Little to address any specific communications. Please refer to the Cabinet briefings already provided, including those from February and August 2021.*

Response to Question 10

10.1 The relevant key decision in scope of the Inquiry for the purpose of this question appears to be vaccine safety, including monitoring and reporting of

adverse reactions. As noted in response to question 9, communications strategies per se do not appear to be in scope of the terms of reference. I therefore limit my response to communications regarding the monitoring and reporting of adverse reactions and the Cabinet briefings from February and August 2021.

10.2 I was not personally involved in much of the public communication about vaccine use. I was and remain satisfied that we received robust advice about available vaccines and the procurement decisions for vaccines. On the basis of the advice received, we considered it important in the interests of public health to ensure New Zealanders had access to vaccines and that there was an appropriate programme to enable access to vaccines as quickly as possible. I was satisfied there were proper processes in place to monitor adverse reactions and that this was publicly available. I was satisfied vaccine mandates were carefully calibrated to ensure they were confined to places of clear risk of transmission and that otherwise the right to refuse medical treatment was maintained.

10.3 In terms of communications about vaccines, this was carried out through a number of platforms and media. I was aware there was a balance to be achieved between the clinical and public policy desire to describe the risk associated with vaccines and the communication imperative to convey the same thing in language as accessible to as many people as possible.

Question 11

A Cabinet decision from February 2021 (CAB-21-MIN-0011) noted that the overarching purpose of the COVID-19 public communications strategy was to build trust and confidence in the COVID-19 vaccines and the Immunisation Programme, to encourage uptake.

a. Reflecting on public attitudes to the vaccines, do you consider that goal was met? Why or why not?

b. How did Ministers balance the goal of promoting uptake of vaccines against respecting the public's right to make an informed choice about their medical treatment?

c. Do you consider the government provided the public with the information they needed to make informed choices? Why or why not?

d. How did the Government balance achieving its goals with respecting individual rights?

Clarification
On 18 July 2025 the Inquiry provided publicly available examples of research into public attitudes about the vaccines and clarified in relation to this question:

> *This question is again intentionally generally expressed and we have not asked Mr Little to respond to specific examples. Mr Little is welcome to identify or respond to particular attitudes which he has experienced or witnessed.*

Response to Question 11

11. The Cabinet decision from February 2021 (CAB-21-MIN-0011) followed a February 2021 update on the COVID-19 Immunisation Strategy and Programme paper, lodged jointly by me, as Minister of Health, the Minister for COVID-19 Response and the Associate Minister of Health. That paper advised that Campaign planning had identified three main phases of work over the following 18 months: Phase 1 (Quarter 1, 2021) – would focus on ensuring people had the correct information about the safety and efficacy of the vaccine, the aim being to address key questions and concerns people may have about COVID-19 vaccines, clarify New Zealand's context compared to other countries, and share information about vaccine timing and sequencing. The aim of Phase 2 (Quarter 2 – Quarter 4 2021) was to encourage uptake, support access to vaccines and address any remaining questions. Phase 3 (2022 onwards) would continue to encourage uptake in the event the campaign continued into 2022. At that stage officials had also planned for five to six different campaign streams that could tailor messaging to certain population cohorts.

a. The high uptake of vaccinations leads me to conclude that the goal of the public communications strategy was largely achieved.

b. The goal of promoting uptake of vaccines was balanced against respecting the public's right to make an informed choice about their medical treatment.

This was reflected in advice Ministers received which, as with much advice we received during the pandemic, drew attention to the fundamental rights confirmed in the New Zealand Bill of Rights Act 1990.

c. I consider the Government provided the public with the information they needed to make informed choices. Information about the available vaccines was widely accessible. Public debate indicated people were aware of the different vaccines and their pharmacological properties.

d. The Government balanced achieving its goals with respecting individual rights by ensuring mandates were justified by clear health objectives to minimise transmission of the virus and protect vulnerable services and relevant workforces. Businesses were left to manage the risks in their workplaces as they were in the best position to make such a judgement in consultation with their employees. My remaining concern as a Minister was the application of exceptions for those covered by mandates. I was personally involved in at least one case where an application for an exception was declined and, like the applicant, I could not understand the reason. I twice advocated for the decline decision to be overturned but officials insisted on upholding the original decision to decline. I was concerned that the rigidity and lack of compassion evident in the decision would undermine public confidence in the exceptions process.

Reflections for the future

Question 12

Sir Ashley Bloomfield, in an interview with Paddy Gower in March 2025, said that leaders should have listened more. Do you share his view? Please explain why or why not.

Response to Question 12

12. The Inquiry has provided me with a link to the interview referred to. In making the statement referred to in question 12 Sir Ashley Bloomfield was responding to the "quick-fire" question:

> *Q: What did you get wrong, and again quick-fire, you know, is there something that stands out that you got wrong?"*

Sir Ashley Bloomfield responded:

> *A "Well as things went by and people's kind of tolerance waned, I think we could have done more listening, you know, because even just active listening and hearing people's concerns and telling them a bit more about the pros and cons of what we were doing that might have helped"*

There is no such thing as the perfect response to a public health event of the size, magnitude and pace of the Covid-19 pandemic dealing with a highly contagious virus with a high risk of serious and life-threatening effects for vulnerable populations in a country whose health system was showing signs of strain even before the pandemic. I am confident Ministers carefully considered the official advice provided to us. That advice covered clinical matters and public health risks and included advice on community sentiment and the growing frustration and exhaustion evident as the response continued. Ministers were sensitive to representations from the community being made to all elected representatives. I am confident Ministers were acutely aware of the restrictions New Zealanders were being asked to tolerate and, by the end of 2021, the growing frustration many were feeling. From the many court decisions on aspects of the pandemic response, some helpful guidance was obtained.

Question 13
Looking back over the 2021-2022 period, what went right, from your perspective? What could have been done better?

Clarification
On 18 July 2025 the Inquiry clarified in relation to this question:

> *It is a curiosity of our TOR that we must not duplicate or repeat work undertaken during Phase One, but we are limited to considering the Phase One findings, and what is publicly available and known to have been received by Phase One. We do not know what Mr Little said to Phase One except to any limited extent that it is recorded by implication in the Phase One report (he is not mentioned by name). Mr Little is welcome to confine his views in response to these questions to matters within the Phase Two TOR.*

Response to Question 13

13.1 My views in response to these questions are confined to matters within the Phase 2 terms of Reference that fell within the Health portfolio relevant to whether key decisions were well informed, and whether those decisions

had unforeseen consequences. The index of documents provided to me by the Inquiry for the purpose of responding to the questions identifies the three specific documents as being relevant to this question. In addition to the three documents referred to in relation to question 13, the index of documents provided to me by the Inquiry for the purpose of responding to the questions identifies two additional specific documents as being relevant to question 14, however, they appear to be more relevant to this question 13. I therefore direct my response to question 13 to the key decisions regarding the use of vaccines that are referred to in all five papers.

13.2 The Cabinet briefing "Pfizer recommendations for decision to use" February 2021, and Cabinet minute "February 2021 update on the COVID-19 immunisation strategy and programme" record that in February 2021 Cabinet endorsed a Decision to Use Framework that set out a process to inform decisions and optimise delivery of the COVID-19 Immunisation Programme in order to support the best use of COVID-19 vaccines in our portfolio. The February 2021 Cabinet Briefing on "Pfizer recommendations for decision to use" was a joint Minister for COVID-19 Response, Minister of Health and Associate Minister of Health briefing. The briefing informed Cabinet that MedSafe had provided provisional approval for the Pfizer vaccine for all age groups except those under 16 years of age. The expert recommendations of the COVID-19 Vaccine Technical Advisory Group (CV TAG) were annexed to the paper. The paper outlined next steps for the roll-out of the vaccine utilising the Sequencing Framework whereby vaccines were being prioritised for certain people while supplies are limited. The paper noted the human rights considerations involved in prioritising access to the vaccines in this way and concluded this was justified in accordance with the Bill of Rights Act.

13.3 The paper noted that the Ministry of Health had already started providing key messages to the workforces outlined in Tier One of the Sequencing Framework, and had planned a number of engagements to enable the

target populations to ask questions and get reliable information about the vaccine.

13.4 The August 2021 Cabinet paper "Decision to use the COVID-19 Pfizer vaccine for children aged 12-15 years" was a briefing from the Minister for COVID-19 Response on making the Pfizer vaccine available to children aged 12-15 following MedSafe provisional consent for its use in that age group. The paper outlined CV TAG Advice that roll-out of the vaccine to the adult population continued to be a higher priority since New Zealand did not at that time have community transmission so there was a low risk of exposure. Further advice on risks and opportunities in light of the emergence of the Delta variant and the ability to vaccinate more people sooner due to an increase in the standard interval between doses was provided by the Director-General of Health. The paper recommended that Cabinet agree to use the COVID-19 Pfizer vaccine for children aged 12 to 15 years in line with the Immunisation Programme rollout to manage the potential risks and equity considerations noted in the paper. Vaccine Ministers were to provide final agreement to the implementation approach prior to opening up invitations for children aged 12 to 15 years.

13.5 The August 2021 Cabinet Minute "Decision to use the COVID-19 Pfizer vaccine for children aged 12-15 years" records Cabinet's decisions. In addition to the recommendations contained in the paper, Cabinet also noted that it was proposed that a whānau/family together approach be taken to the rollout of the vaccine to children aged 12 to 15 years.

13.6 As noted in the Phase 1 Report, vaccination was a crucial pillar of New Zealand's long-term approach to managing COVID-19. This is covered in detail in chapter 7 of the Phase 1 Report and I do not repeat that information here. What went well in relation to vaccine use is documented in section 7.3.1 of the Phase 1 Report and includes that independent studies have confirmed that vaccination together with other elements of the response enabled New Zealand to experience one of the lower pandemic mortality rates of any country in the world. The Phase 1 Report also found that the vaccine rollout was less successful at delivering

equitable coverage across different population groups with delays in ensuring access for some higher risk groups including Māori and Pacific peoples. This is an area where we could have done better since equity considerations formed part of the decision-making.

Question 14

Overall, what do you think New Zealand needs to improve or do differently to ensure the health system and leaders are prepared for the next pandemic?

Clarification

On 18 July 2025 the Inquiry clarified in relation to this question:

> *It is a curiosity of our TOR that we must not duplicate or repeat work undertaken during Phase One, but we are limited to considering the Phase One findings, and what is publicly available and known to have been received by Phase One. We do not know what Mr Little said to Phase One except to any limited extent that it is recorded by implication in the Phase One report (he is not mentioned by name). Mr Little is welcome to confine his views in response to these questions to matters within the Phase Two TOR*

Response to Question 14

14.1 My views in response to these questions are confined to matters within the Phase 2 terms of Reference that fell within the Health portfolio relevant to whether key decisions were well informed, and whether those decisions had unforeseen consequences.

14.2 In the name of efficiency and effectiveness, the government has long looked askance at processes or systems which have built in redundancy or spare capacity. For an event like the pandemic, which is one of low probability and high impact, it is easy for processes designed to respond to it to be left, over time, to deteriorate and be poorly tried and tested. It is important for future pandemics that the government is able to draw on public and private resources to stand up an effective health response by harnessing available, including redundant, health services capacity, quarantine facilities, decision-making systems utilising public and private actors and sources of information and means of communications to inform and reassure. Any future response will need to plan to take account of a

changed information ecosystem in which any information, regardless of accuracy, authenticity or origin, is weighed by many as having the same probative value.

Date: 4 August 2025

Signature: 

Hon Andrew Little