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RESEARCH NOTE

LIFTING THE LID:
A CRITICAL ANALYSIS OF THE COVID-19 PANDEMIC MANAGEMENT IN NEW ZEALAND

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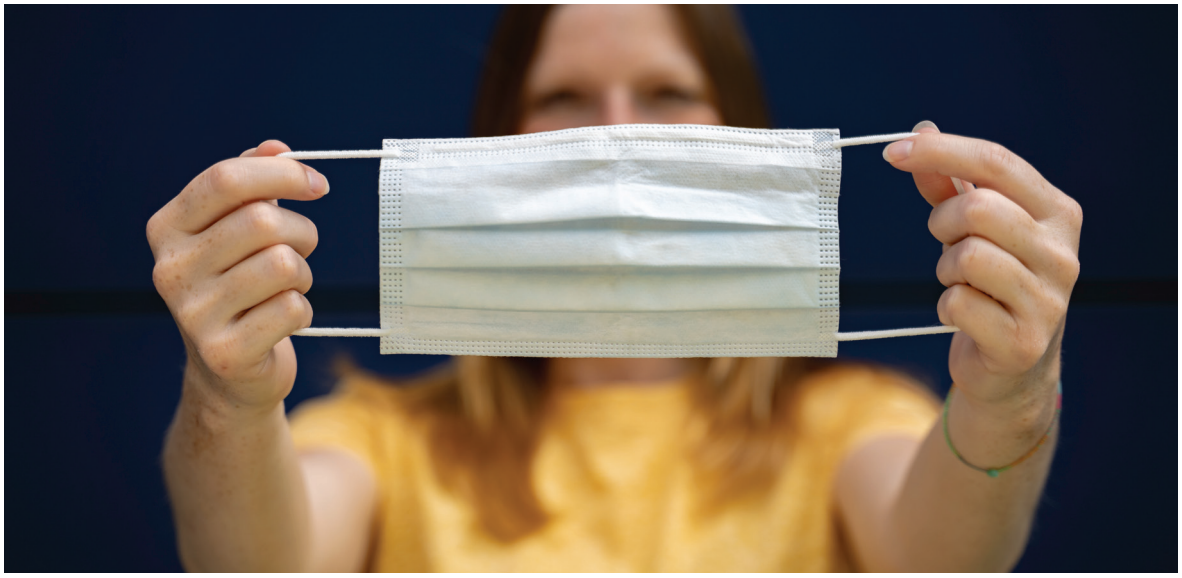

THE NEW ZEALAND INITIATIVE

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About the New Zealand Initiative

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Introduction and Summary

A pandemic caused by the SARS-CoV-2 virus (COVID-19) continues both worldwide and in New Zealand. Although estimates are that half the New Zealand population have been infected, more likely almost every citizen has come into contact with the virus in some way. New Zealanders continue to be reinfected by old strains of the virus and by emergent strains. About 0.1% of those who have reported infections have died. At the triennial anniversary of the epidemic in New Zealand, a review is timely to identify what can be done better and to inform future pandemic planning.

Initial strategy was fine, but execution lacked adaptability and agility.

Our concern is not with the initial strategy adopted to manage the pandemic. Our geographic isolation was a huge advantage in initially keeping the pandemic out of the country. While we reacted 'relatively' quickly when the virus finally arrived, we had plenty of warning and need not have waited as long as we did. Reacting to local outbreaks by a combination of isolation and lockdown to buy time to build health system capacity and await an effective vaccine also made sense. More effective testing and tracing should have reduced the reliance on costly lockdowns. However, absent a vaccine, the political priority was always going to be on protecting the health system from becoming overwhelmed.

While this initial strategy made sense, the execution of that strategy fell short. We do not intend a forensic analysis of the various missteps and policy flip flops (e.g. mask wearing requirements and rapid antigen testing). Doubtless the Royal Commission will explore those in detail. Given New Zealand did not have a meaningful pandemic plan[1], we had to "*make it up as we went along*." Mistakes were inevitable.

Our concern is not that mistakes were made, but that our response lacked adaptability and agility. As an illustration, consider the key measure of contact tracing performance. This was well below the sensible identified standard[2] during the first outbreak and showed no improvement across successive outbreaks until it was overwhelmed by the 'Delta' and 'Omicron' strain outbreaks in late 2021 and 2022.

Implementation was poor because it was politicised.

Political involvement was essential given that the strategy required imposing restrictions on personal freedoms of movement and association. However, that involvement need not have extended into the on-going governance of strategy execution. We have many models, like

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[1] In 2006, the New Zealand Ministry of Health (MOH) produced a pandemic planning guide (is-07-06-pandemic-planning-guide). As far as we can see, the only plan that resulted was specifically for influenza and lacks tactical specificity (influenza-pandemic-plan-framework-action-2nd-edn-aug17).

[2] Dr Ayesha Verrall, "Rapid Audit of Contact Tracing for Covid-19 in New Zealand", University of Otago 10 April 2020. That Audit suggested reporting against several critical priority performance indicators.

the Reserve Bank, where the essential political decisions are successfully separated from the administration of Government strategy and directives. These models have evolved because Governments have come to accept that there are some critical areas of public policy where politically driven execution of policy undermines the objectives of that policy.

Our main argument is that the politicisation of the execution of the response to the COVID-19 pandemic led to a lack of adaptability and agility and so a response that was more costly than necessary. Managing political risk produced a very natural desire to paint our response as the envy of the world, to claim a monopoly on the truth, to put the best possible "spin" on events, to marginalise criticism and monopolise execution. The facts are made to fit the political narrative in order to maintain public confidence in the chosen response. The use of alarming computer scenarios of widespread hospitalisations and deaths generated a high degree of fear that encourages people to place their faith in authority. None of that is conducive to admitting shortcomings, learning from them, and adapting your response. Moreover, they encourage an extended "at all costs" response rather than a more balanced approach to costs and benefits, especially as more becomes known.

These costs reach beyond the disruption to almost every aspect of life during the protracted "zero- COVID-19" phase and the subsequent impact on inflation, on health worker morale and well-being, on healthcare delayed and on a health system that is now in crisis. The response also became an increasingly divisive issue. Although it is more difficult to quantify, we are now a less cohesive society than we were at the beginning of the pandemic; one that is less trusting of Government and the media. Polling suggests that the initial and overwhelming public support for the Government during the initial phase of the COVID-19 response steadily declined and was significantly eroded by early 2022.

We were not the only country where the management of the pandemic was politicised. In some countries, this was more exaggerated and it's noteworthy their outcomes were very poor (e.g., Brazil, UK, USA).

We draw five related lessons that would leave us far better prepared for the next pandemic:

1. The lack of a plan to deal with a virus like COVID-19 was telling. Different threats will trigger different responses. While any plan will need to be modified as more becomes known, it is important to have thought through a wide range of scenarios in advance. Moreover, there are critical components of any likely response that need to be identified in advance and regularly tested and reviewed to ensure that they will be effective when needed. These include ensuring sufficient physical capacity can be made available (for quarantine, for testing, tracing and immunisation, PPE stocks, ICU capacity and so on) as well as clarity around who is best placed to do what to both keep threats out and contain any outbreaks. It is telling, for example, that Government has agreements with primary sectors to ensure biosecurity risk is well managed but nothing similar exists to manage pandemic risk. We need a pandemic management plan, preferably one that has broad political support.

2. Ministerial involvement in execution was counter-productive because it places too heavy a weight on managing political risk, with the implications noted above.

Execution of the plan and responding to any explicit and transparent Government directives should be the responsibility of a single co-ordinating body with professional governance that is independent of, and accountable to, ministers.

3. The response was overly reliant on the public sector. Co-ordination and accountability also need strengthening. The Ministry of Health had little operational experience. Private individuals and organisations that had critical expertise and experience should have been encouraged to participate and used more effectively, with some respective roles agreed in advance (as we do for biosecurity). The responsible co-ordinating body needs to have the authority to call on help across both private and public sectors.

4. We lacked critical infrastructure, so some infrastructure investment is essential to ensure we have the physical capacity to respond to likely threats without over-reliance on protracted lockdowns.

5. We did not use the time that the strategy bought us to build health system capacity. Workforce was, and is likely to remain, the limiting factor. Attention to the retention and extension of existing health workers and the recruitment of new workers is the only way in which to boost system capacity in reasonably short order. Protecting the health of these workers, for example by effective PPE, is also critical. While we remain more dependent on immigrant health workers than any other OECD country, attracting and retaining these workers has to be a critical part of this approach.

Figuratively caught with our pants down

In February 2020, New Zealand was not prepared for a coronavirus pandemic. This contrasted with those countries who had been sensitised by previous SARS and MERS outbreaks, who quickly stood up management agencies and began active management of their borders and other public health measures.

At outbreak, no one had access to an effective vaccine. However, many had well developed pandemic management plans, which New Zealand did not. We did and do have significant geographical, demographical, climatic, and cultural advantages, which in our opinion were largely squandered. Unfortunately, New Zealand also had a public health unit system that had proved inadequate in regard to recent measles and influenza outbreaks, and to a contaminated water problem in Hawke's Bay. The country had limited quarantine capacity. The subsequent decision to use hotels, many of them in the Auckland CBD, proved to be a mistake. Perhaps most importantly, our health system lacked the capacity to cope with a surge in demand. As has often been quoted, on a capitated basis, New Zealand had only one third of intensive care beds compared to Australia and only one tenth of that in Germany. The most important shortfall, however, was not so much in equipment and resources, which could be reasonably quickly purchased, but rather a shortage of critical health workers.

The only viable strategy then was to use border control and other public health measures to minimise disease incidence and to delay any significant disease peak until a vaccine was

available and the community was vaccinated, and the health system capacity had been substantially increased. This 'minimise and delay' strategy was adopted successfully by most countries.

Although the rhetoric of going hard and early was and still is widely accepted, New Zealand actually went hard but late. The lateness of our response was almost certainly a consequence of inadequate prior planning exaggerated by the indecisiveness of the World Health Organisation. By the time we closed the border on 19 March 2020, many of the viral subtypes involved in the first outbreak had already been escorted into the country by their human hosts. The first outbreak then in early 2020 was arguably largely avoidable.

Several further outbreaks occurred in 2020 and 2021. These were characterised by failures of border control and quarantine, lax testing, and by inadequate contact tracing capacity. Despite the frequent claims of learning and adapting, it is noteworthy that key public health measures showed no improvement across subsequent outbreaks until existing capacity was completely overwhelmed by the "Delta" and "Omicron" strain outbreaks of 2021 and 2022.

The major "Delta" strain outbreak occurred 18 months after the onset of the pandemic in August 2021 and resulted in Auckland, which is responsible for about 40% of the national GDP, largely being shut down for more than 100 days. Although a vaccine had been available since early in the year, only 20% of the New Zealand community was vaccinated. In addition, the health system capacity was not materially different from that in February 2020. Overall, the 'minimise and delay' strategy had failed – not because it was flawed, but because it was not well implemented.

The central question is, what led to this failure?

The chosen public health measures were in accord with international best practice. As for the overall strategy, the problem was not with the measures *per se*. We believe that the answer to this question is that the national response to this pandemic was characterised by problems with both governance and management, which we discuss in the next section of the paper.

Another contributory factor to the failure was a strategy drift. During the first lockdown in early 2020, the pandemic governors 'adopted' an unobtainable zero cases ambition which was later changed to zero deaths. Viral disease eradication is possible, given appropriate vaccines and a co-ordinated and comprehensive global response. Smallpox and polio are good examples. Unfortunately, neither of these conditions for eradication exist for COVID-19.

As a generalisation, we do not approach any disease from a zero-occurrence perspective. To do so would require an explicit risk appetite. Given that health capacity is largely fixed at any point in time, then this situation can be considered as a zero-sum game. That is, increased or new investment somewhere has to be matched by a disinvestment somewhere else. Specifically, how many job losses, business failures, lost learning years, delayed cancer diagnoses and treatments, new or worsened mental health problems, and how much social

disruption and domestic violence, and or health workforce morbidity would be an acceptable 'price' for every avoided COVID-19 death? Consistent with our perspective that governance of the pandemic was often inadequate, such a risk assessment was never undertaken. If it had been, then the little research that was done suggests that the cost of an avoided COVID-19 death was much higher than the cost of avoiding death from other causes. In short, the cost was disproportionate to the risk.

In New Zealand, the number of deaths directly or indirectly attributed to COVID-19 is several thousand at time of writing. The received mortality rate of 0.1% is almost certainly exaggerated. In contrast to the number of cases reported by the Ministry of Health, on the basis of an occupational health database that we manage[3], the true number of cases is probably double that recorded. Consequently, the actual mortality rate will be closer to 0.05[4].

Given the very high cost of our response to the pandemic, this mortality is only relatively and acceptably low if the initial estimate of "tens of thousands of deaths" is considered credible. Those estimates were based on a New Zealand adaptation of an Imperial College of London model that has been shown to significantly over-estimate risk. The New Zealand modellers had to use international data because no local data existed. As such, the local forecasts are not credible. What that modelling did achieve, however, was to generate significant levels of fear and anxiety (including among health workers, which persists). This has had significant health and social consequences.

Hubris[5], propaganda[6] and flaws in both governance and management

The flaws in governance and management of the COVID-19 pandemic have to be seen in the context of New Zealand's well-developed approaches to governing complex entities and to the nuanced and competent national management of biosecurity risks.

On governance

Complex entities, such as ACC, the Reserve Bank, and the Superannuation Fund, have well-developed governance models. The responsible minister appoints a board of governors who are tasked with day-to-day governance. The minister retains responsibility for legislation and overall mission of the entity, and determines reporting parameters. A Minister who disagrees with a Board can always replace it or direct the board to act in a particular way. However, these directions need to be explicit and transparent, so if Ministers want to overrule a Board the public knows where the responsibility lies. Democratic accountability is maintained.

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3 The New Zealand occupational diver medical database, which was accessed anonymously.

4 cf., influenza death rates, which are about 0.01% of the total population per annum. The number of influenza cases per annum is not known with any certainty such that the death rate in infected people is not known.

5 Hubris is defined here as excessive pride or self-confidence.

6 Propaganda is defined here as information, especially of a biased or misleading nature, which is used to promote a political cause or point of view.

The board is both technically and governance competent. By contrast, day-to-day governance of the COVID-19 pandemic was undertaken by politicians, as was the case in many other countries with usually similar problems.

There are two reasons why direct political governance in this context was and is not a good idea. First, few ministers would be considered to have the necessary experience and training to be appointed as a director to a commercial board of a complex company. More fundamentally, balancing economic and livelihood risk against health and well-being risk is extremely difficult. It becomes almost impossible when political risk is added. This is not a criticism of politicians *per se*, but simply a recognition that politicians have to win a popularity contest every few years. In our opinion, the governance of the COVID-19 pandemic in New Zealand was unduly attentive to political risk, which delivered significant political reward for the Government in the 2020 election. Forcing political directives to be explicit and transparent makes it far less likely that political considerations will override health and economic considerations.

As already cited, a lack of governance experience was evident in the absence of any determined risk appetite. Possibly more telling, there was also a failure to accept appropriate accountability. When it was discovered that not all border workers were being tested and so on, ministers expressed their disappointment and surprise. While it is easy to feel sympathy for them in this context, a key responsibility of good governance is accountability. It is not enough to issue a Cabinet Minute and expect key functions to occur. A lack of awareness of a failure to implement is a failure of governance. Imagine an automotive company director arguing that they should not be held responsible for their company's most popular car model having faulty brakes because they did not know that they were faulty. They would be quite quickly advised by the prosecutor that their lack of knowledge was the fundamental reason for which they were being prosecuted.

The impact of attending to political risk manifest early as hubris. Our response was touted as being the best in show and the envy of the world. While a "best in show" culture helps garner support for the Government of the day, it also leads to complacency and makes it hard to admit mistakes, learn from them and to adapt because every adaptation suggests that local practice may not be "best". Consequently, the New Zealand response to COVID-19 was not agile. Although the invariable response to recognised shortfalls and problems by the governors (and managers) was that they were recognised and corrected, the reality was that key public health measure performance did not improve between successive outbreaks.

The other problem with this culture is that it inevitably leads to a practice of fitting facts to the chosen narrative, in other words, propaganda or "spin." When those few journalists who were holding the Government to account obtained information through the OIA[7], albeit delayed, it showed that on a number of occasions the information provided to the public was known to be false at the time of delivery[8]. It is understandable that information management in times of crisis is difficult. However, there is rarely a good reason to mislead

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7 Official Information Act.

8 Examples from early in the pandemic include claims about influenza vaccine and PPE supply.

the public. At least, this leads to a loss of confidence and trust. This is fertile ground for conspiracy theorists and movements and unfortunately disinformation became a noticeable feature of the New Zealand experience of the COVID-19 pandemic.

Finally, it is noteworthy that the 'political theatre' of the daily announcements from the governors and managers added considerably to the overall level of community anxiety and fear.

On management

As a result of (and to actually exaggerate) problems in governance, day-to-day management of the COVID-19 pandemic was given to the Ministry of Health. This is primary a policy ministry; one that was widely recognised as being largely devoid of meaningful tactical or operational experience. To task such a ministry with the management of one of the most complex health and social challenges in recent New Zealand history was inadvisable.

The slow and contentious vaccination of the country is a good example of the predictable shortcomings.

First, there were inexcusable problems and delays in contracting with the vaccine manufacturers. The suggestion that New Zealand was standing aside until more needy countries were vaccinated first may be an exercise in good global leadership, but is not acceptable when it is at the expense of the New Zealand public and in conflict with the central strategy of delaying and minimising disease until the community was vaccinated. It is more likely that this suggestion was a fiction to cover the problems in contracting and supply.

Second, the management of the vaccination was conducted by the Ministry of Health and the District Health Boards – neither had the necessary intimate community knowledge. Extraordinarily, primary healthcare providers were excluded until late. By contrast, they should have been given leadership of the vaccination program, particularly for vulnerable people. Every general practice, and other primary care providers, including *Iwi* health and social services, and community trusts etc., could have quickly provided a list of their vulnerable populations. For many general practices, this would simply have constituted a printing of the influenza vaccine recall list. Those primary care providers should then have been tasked with locating and vaccinating these identified people. Using best behavioural economic practice, a capitated lump sum should have been provided for this exercise for each provider and or provider group, with a clawback for every vulnerable person who the providers failed to vaccinate. The next appropriate cohort to vaccinate should have been those known early in the pandemic to be the primary disease vectors, namely people between 25 and 40 years old. Instead, New Zealand took a relatively unscientific descending age cohort approach.

Using the type of thinking we employ for biohazard risk management, a management group should then have been constructed by borrowing logistical experts from companies such as Freightways and supply chain experts from companies such as Woolworths and Foodstuffs.

This approach is agnostic of whether these experts are privately or publicly employed, but instead focuses on the relevant expertise needed (to ensure vaccine supplies and delivery).

Finally, punitive commentaries and the holding of large sections of society somewhat to ransom until almost everyone was vaccinated, led to the inevitable antagonistic division of society into the vaccinated and nonvaccinated. What was required instead was an enabling approach of offering privileges to the vaccinated. This highlights another major criticism we have of our approach to the COVID-19 pandemic. It lacked the necessary level of humanity. Neither the Government nor the Ministry of Health, or their public health advisors were sufficiently attentive to the 'human factor'. Many of the measures they took caused significant community distress. The programs were designed for an inherently rational species that does not exist. *Homo sapiens* instead are typically predictable in their behaviour but are frequently irrational[9]. Any future pandemic plan has to be informed by people who better understand actual human behaviour.

The unfortunate legacy of our pandemic response

The way our response was executed has also created a nasty legacy. The impact of excessive stimulus on inflation and the balance of payments seems likely to require a recession to put right. The combined effect of delayed treatments and heavily restricted access to the foreign health workers we need[10] – and were able to attract pre-pandemic - means that people are now having to wait far too long for care from a health system many participants now describe as in crisis, if not broken. Moreover, some of the rules imposed during the pandemic were inhumane and the consequent anxiety, family and social disruption will further contribute to long-term morbidity and mortality.

Perhaps more troubling, albeit more difficult to quantify, is the impact of the way the pandemic was managed on social cohesion, including trust in Government and the media.

Success of the strategy largely depended on a high degree of compliance with public health measures. A significant level of voluntary compliance was achieved by the fear that an outbreak would cause widespread hospitalisation and death. The Government used particularly alarming scenarios from assumption-driven, computer-based, and highly questionable models to drive this message home.

Frightened by the existential risk of a respiratory virus and forecasts of Spanish-flu like death rates, we were happy to accept edicts that people would be required to die alone and that women would be required to be alone after they gave birth. If any of us had been asked in 2018 if it was possible that such a situation could arise, then our response would have been uniformly "*no, that is not how we behave and not who we are*". Regrettably, it is how we did

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[9] Irrational in the sense that people often do not behave as a dispassionate and fully informed individual would be expected to behave. Some would argue that, because gathering and making sense of information is expensive people are "rationally ignorant', rather than "irrational". The key here is the predictability of behaviour rather than its rationality.

[10] While access to the supply of foreign doctors seems to have been maintained during the border restrictions, the same is not true for nurses. The data suggests that we are about 1,000 foreign nurses short of the number that we would usually attract and that this number has not been made up as border restrictions have been lifted.

behave. A level of hostility arose towards both neighbours and in particular toward strangers. Supermarkets became a fear-avoidant battleground. As cited already, society fragmented into antagonistic factions. Conspiracy theorists thrived.

The Government also became more authoritarian as restrictions on personal freedoms became more burdensome: i.e. it favoured or enforced strict obedience to authority at the expense of these freedoms. The Government claimed a monopoly on the truth, a claim that was increasingly difficult to justify as rules kept changing and claims proved either biased, misleading, or untrue.

While some move in this direction was probably inevitable, it came in a flinty, unforgiving form. Despite exultations from the Prime Minister for kindness, this was not a feature of our behaviour, nor that of her or her Government. Individuals such as a Vietnamese student, women inaccurately described as sex workers and gang affiliates, Samoans in South Auckland worshipping as is their custom and need at their local church, and others were identified and essentially shamed. Perceived rule breakers were demonised, with no apologies forthcoming when it was later discovered that no sin had been committed.

While the “team of 5 million” started as an expression of collective solidarity it gradually became a source of derision and division. As time went on, fewer Kiwis felt part of the team: kiwis stranded overseas facing a lottery to get home; private individuals and businesses that were excluded despite being keen and well placed to help; people suffering or mothers giving birth alone or families not being able to attend funerals for their loved ones; businesses that bore the brunt of costly lockdowns and, as time went on, those who were hesitant or sceptical of the vaccine. Critics were discouraged and side-lined and, with a few notable exceptions, the media were largely compliant with this flinty authoritarianism. Even well-intentioned criticism of the Government seemed to be unpatriotic to many.

No doubt sections of the media (and academia) thought that promoting the Government’s policy was the right thing to do to achieve uniformity of purpose and action. Initially, most of the media promulgated the offered propaganda without critical analysis. A small group of journalists, much to their credit, did not join this ‘cooperative’ and became increasingly polarised and critical. However, it is fair to say that the media did not play its usual role in holding the Government to account. In this environment we should not be surprised when the public start to look for other sources of information, including from social media. Here the absence of fact-checking and the ability for anonymous personal attacks makes it both a fertile breeding ground for conspiracies and cancel culture, further undermining social cohesion.

Universities hold themselves out as bastions of freedom of thought and speech. It is difficult in this context to strike a balance between being a good team player and supporting worthy national causes on the one hand and being an independent critic on the other. Again, some academics were happy to provide critical commentary but, in our opinion, most of academia did not get this balance right and were parties to the Government’s propaganda. Many of them who rely on significant Government funding also failed to disclose their conflicts of interest. When we decided to comment on the management of the pandemic, the response from our academic colleagues was largely negative. By way of emails, letters to editors, and

lobbying, they attempted to have us gagged. In their opinion, we had no right to provide an opinion because we did not belong to their guild and that our duty was to "be helpful" and to support the Government.

Collectively then, our media and academia did not fulfil their duty of holding the Government to account. Given the heightened sense of fear, the natural desire for the Government to be successful in protecting the public from "thousands of deaths" and the lack of media scrutiny, it is no surprise that the main opposition party found it difficult to gain traction.

On the other hand, the Government should be acknowledged for establishing the Epidemic Response Committee of Parliament and Simon Bridges congratulated for the way it was managed: i.e. investigating issues and hearing from experts. However, this exercise in effective democracy was wound up in 2020[11]. That made effective accountability to parliament even more difficult.

The legacy of our pandemic response is not a pretty one. In the short term, a recession to reign in the excess demand created by overly stimulatory monetary and fiscal policies, albeit exacerbated by international conditions. Getting the books back in order will also require a return to a more disciplined approach to public spending than we have been used to. At the same time, we will need to address a health system crisis that is at least exacerbated by the pandemic response. More fundamentally though, we are a less cohesive society with less confidence in the institutions that sustain a healthy democracy and less confidence in our own willingness to resist a more authoritarian style of Government.

Hopefully, we can put all that behind us. We can take some comfort from polling suggesting that, by late 2022, most of us were looking for a change in style and direction. However, it is essential that we draw the right conclusions from our experience with the COVID-19 pandemic response and learn from that experience. Future responses need to be more proactive and adaptable as well as less politicised and self-congratulatory. That will require more foresight and better planning with greater attention to enhancing our physical capacity to respond. It will also require us to draw on our experience with governance models that successfully reduce the incentives to politicise implementation. We should also learn from our approach to biosecurity and engage private sector participants when they are best placed to deliver key elements of the response. Finally, our response needs to be guided by a consistent application of an agreed risk appetite that is informed by an analysis of the costs and benefits of various courses of action.

[11] Notably, even when it was still running, Government ministers sometimes refused to appear.

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