Hansard transcript

Briefing on the Government’s response to COVID-19

Health Committee

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## Members

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## Witnesses

**Strategic COVID-19 Public Health Advisory Group**Professor Sir David Skegg, New Zealand epidemiologist  
Dr Nikki Turner, New Zealand researcher

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Craig Tēnā koutou katoa, and welcome to the third of three sessions of the Health Committee for this week. So today we’ve got with us Professor David Skegg and Nikki Turner from the Strategic COVID-19 Public Health Advisory Group, so, welcome, Professor Skegg and Dr Turner—lovely to have you with us. So what I thought I’d do is just hand over to you briefly to introduce yourselves and also the work of the committee, and then we’ll just open up for questions. And I understand we have up to 90 minutes with you today if we need it. So, handing over to you, Professor Skegg, and thank you for coming on board.

Skegg Thank you very much, Madam Chair. The group that I’m chairing has six members, and our terms of reference state that the purpose of the group is to provide independent advice on the ongoing COVID-19 response, informed by expertise in epidemiology, infectious diseases, public health, and modelling. I would stress that we are an independent group. The Ministry of Health don’t sit in on our meetings, and our written reports go to Ministers without them seeing a draft. It’s very common with these sorts of committees that you put in a draft for people to suggest corrections and so on, but the reports that the public have now seen are exactly what we submitted, and they weren’t seen by the ministry or by Ministers in advance, and we were given an assurance that our reports would all be made public. We had our first meeting on 23 April, so we’ve only been going for four months so far. And you’ll have seen our written reports, and I’ve also briefed Ministers verbally on quite a number of occasions.

I’d like to introduce my colleague Dr Nikki Turner, who is also on the advisory group. Dr Turner’s an expert on immunisation, so I’ll be referring questions about vaccines and the vaccination roll-out to her. She’s also in general practice, so she brings the perspective of primary healthcare and, indeed, of the health system generally.

I think it’s important to remind members that there are other advisory groups, including the one chaired by Sir Brian Roche, which has an even longer name than our one. In fact, I always have to look it up. It’s called the—somewhere here, I’ve got it. Yes: the COVID-19 Independent Continuous Review, Improvement and Advice Group, and they’re the folk who have been monitoring activities such as the contact tracing and the MIQ facilities, so they would be the best people to comment on the management of the current outbreak. Obviously, we’re happy to talk in general terms about that, but we’re not directly involved in the management of the current outbreak.

You’ll have seen that our main role so far has been to advise on the overall strategy in New Zealand, and also on plans for reopening our borders once the vaccination roll-out is completed. You’ll also have seen that we’ve concluded that the elimination strategy is the best option at this stage of the pandemic. We’ve been careful to define what elimination means and doesn’t mean, and we’ve also emphasised that this strategy needs to be reviewed regularly, and I’m sure it will be reviewed before the start of next year when we can consider reopening our borders.

I think the last thing I’d just say is, obviously, at the moment our number one priority is to stamp out the outbreak that we are currently experiencing, and the other vital priority is to vaccinate as many New Zealanders as possible in the next months ahead. Thank you.

Craig OK, thank you, Professor Skegg. Just wondering whether you’d like to say a few words briefly, Nikki, before we open up for questions?

Turner I think David said most of it, thanks. I’m here to support and take questions, and I particularly have extensive background in vaccinology and in primary care, so yeah, just happy to roll into questions, I think.

Craig Wonderful, thank you.

Bishop Thank you, Professor, and thank you, Dr Turner, and can I, I suppose on behalf of the committee and New Zealand, extend our thanks to you for all your hard work on this expert group, which is providing enormous value for the country. So thank you very much for that. We’ve got quite a bit of time with you but there’s quite a lot to get through. I suppose where I’d like to start is in relation to paragraph 7 of your last letter to Dr Verrall, around reconnecting to the world, which has been made public but it’s got some relevance to the current outbreak as well. So, in paragraph 7 of the letter you talk about, basically, the problems of returning travellers being required to quarantine at home, and you talk about what we did last year when that was required, basically, for a while. You said “they didn’t do so consistently, measures to check on their adherence turned out to be largely ineffective.” You basically recommend that on a trial basis for reconnecting to the world, but it’s come up again in the last day or so in the context of the Minister saying that one option for quarantine, as a result of the latest outbreak, is that people may have to return to home self-isolation.

I was just wondering if you had any views or comments on whether or not that would be an efficacious or sensible thing to do, in light of what you’d previously said around the problems last year?

Skegg Do you mean home self-isolation of people who are testing positive in this outbreak?

Bishop Yeah.

Skegg Yep. Well, clearly it would be a second-best. The ideal situation is for people not to have to isolate with other members of their household—that’s true with COVID-19 in general, but it’s particularly true with the Delta variant because it is so infectious. But, obviously, in an outbreak like this, one has to do the best you can, and I assume that if we ran out of rooms in which to quarantine people who are infected, that would be the next best option.

Bishop Yeah. On a related note, one of the things that I think a lot of us have been grappling with is just what sort of vaccination coverage across the population, but also sub-groups of the population, is required for reopening to the world? And I think, you know, the Prime Minister outlined the plan or strategy a couple of weeks ago. That’s obviously been overtaken by events, so I suppose the next thing people have started thinking about is, what is the level of coverage in the community that we need to avoid or limit lockdowns in the future? Now, the Government’s current strategy is to just go for as many people are vaccinated as possible, which, of course, everyone, or at least most people, agree with. But I just wonder what work your committee has done on what level of coverage is required in the 12-plus or 16-plus population in order to limit lockdowns into the future.

Skegg Yeah, first of all can I just say I don’t think the Government’s strategy has been overtaken by this outbreak. This outbreak was entirely predictable, and, as you have noted, we actually predicted it. It’s no comfort to say that, but, you know, I’ve felt like a prophet of doom for the last few months. I’ve kept saying “We will have a lockdown. Sometime this year it’s going to happen”, and sure enough, it has.

But coming back to the question about targets for vaccination, that was something we were directly asked to advise on and our group had a consensus that it didn’t make a lot of sense to pluck a figure out of the air as the Australians have done—like 70 percent or 80 percent—because, basically, the more people are vaccinated the better; the more options you’ve got. It’s quite clear from modelling in New Zealand and around the world that with this pesky virus you don’t reach some magical stage of herd immunity where you can just rely on vaccination. So however high the vaccination coverage, we are going to have to take other precautions—precautions at the border, to make sure we don’t have lots of people coming in carrying the virus; and also public health and social measures within the country. Even in Australia it’s clear that, even if they get a really high vaccination rate, they’re expecting to have to do a lot of things like test, trace, isolate, and quarantine.

Turner Could I just add something to David’s points, is that of course it’s not about an absolute number, but it’s about what we call “heterogeneity” in a population. That, really, the focus should be on what we would call “equity” here—that you could get a really high number but if you’ve got small populations who are under-vaccinated, then your virus will surge within small groups, as we’ve seen with other vaccine-preventable diseases. So the focus is as much on getting high coverage as it is on making sure you don’t leave population groups behind.

Bishop Look, I 100 percent understand where you’re coming from. I’m not so much asking for a target; I’m asking for what work you’ve done, if any, with the modelling experts around what the numbers mean. So people talk about high coverage, but there’s a big difference between a high coverage of 85 or 90 and a coverage of 70, right—85, 90 does different things to your population in terms of the number of people who are hospitalised, the number of people who get sick, the number of people who get COVID. It’s just a maths game, right? It’s just a simple maths thing—well, not simple, but it’s maths.

Skegg No, it’s not simple.

Bishop No, it’s not simple, but, fundamentally, it’s a maths problem. So what I’m asking is what work you’ve done, if any, in relation to what the numbers mean, because I think what people are struggling with a bit is people say, “Well, we need high coverage.”—OK? That’s good? We all accept we need as high as possible. But we also need to have some—I would argue, anyway—work done around what the numbers mean in terms of hospitalisations and sickness, etc.

Skegg Yeah, well, unfortunately, there’s no simple answer to that, because vaccination is only one of the things in the mix. Obviously, we would love to see over 90 percent vaccination coverage, and as Nikki Turner said, we don’t want particular groups to have less coverage, otherwise we’ll have outbreaks and they will suffer. But we won’t just rely—even at over 90 percent, we couldn’t just rely on the vaccination. So a lot depends on how many people we have coming in, carrying the virus. It depends on whether we have to adopt other measures, like physical isolation, mask wearing, as most countries around the world are now practising. It depends on how good our contact tracing is. So it depends on all of us, actually—whether we go and get tested every time we have cold or flu symptoms. So, you know, I’d love to be able to answer your question, but there’s no way it can be answered, and that’s why we’ve recommended this phased reopening: we think that the sensible way for us to move, once the vaccination roll-out is completed, is just to start opening the thing in a step-wise way, and see what happens. So—

Turner Maybe if I could add a bit more to David too. You’ve all, by now, heard of the magic (R0), which is the reproductive number—and all the modellers that we’ve been working with, and they all work in slightly different ways and use slightly different scenarios and come up with slightly different outcomes. But the focus on all the modelling is to put the different elements that David’s referred to into your model to get your reproductive number below one, which means that one person spreads it to less than one person. Now, there are models out there that we’re looking at and we’re reviewing regularly, and they’re all focused on all the different elements of the puzzle, which are all a moving feast, and I’d be very cautious about using one as the magic answer—but using them as a tool, as the situation evolves, depending on the amount of virus in the community, depending on the amount of resources in our public health services and our primary care. They’re all within the mix, so it is a bit of a complex model, the harder you look at it.

Bishop Just one final question before I move on—this is a really interesting discussion. In relation to your advice that once everyone in New Zealand’s had an opportunity to get vaccinated before the end of the year, starting from next year we could slowly reopen the borders to allow double-vaccinated passengers from low-risk countries to come into New Zealand. What modelling have you done around what that means in terms of COVID coming into New Zealand? The reason I ask that is I think it’s reasonably clear if you look at just the maths again: even allowing double-vaccinated passengers from low-risk countries to come into New Zealand will mean that COVID turns up in New Zealand, because people who are double vaccinated can still carry it and still transmit it. What does the modelling show around how much COVID will come into New Zealand under those scenarios?

Skegg Yeah, can I just make a general comment to caution you about putting too much faith in modelling? You know, modelling, as a famous person—it’s always attributed to Einstein, but it wasn’t Einstein—but a famous person said, “All models are wrong; some are useful.” And modelling can’t actually answer these questions with any confidence. The fact is, we’re not just talking about people being double-vaccinated. Our group has recommended a whole chain of precautions, you know—pre-flight testing, testing at the border. We don’t yet know even what kind of test will be used, so that’s going to be a crucial factor. You’ve already mentioned the country they’re coming from, and then there are various options available for testing after they’ve arrived here, or a shortened period in MIQ, or home isolation, and so on. So what we believe is that we should start in the most cautious way, and roll it out and monitor very carefully what happens. Although it will be possible to do some sort of modelling exercise, and people may well do that, it actually won’t give us a definite answer. Ah, you’re muted.

Seymour Thank you for that helpful information. Great to see you back, Professor Skegg. I just had a question for Nikki Turner, off the back of the vaccination discussion. There’s a lot of evidence emerging from around the world of vaccine fade. It appears the efficacy of the Pfizer vaccine declines over time, and at least some countries—particularly Israel—that started earliest are experiencing that and are starting to talk about booster shots, an actual third shot. I just wonder if you have advised the Government, Dr Turner, about the need for booster shots? I think it’s particularly important, because, as we’ve seen with these vaccines, if the Government doesn’t get its order in quickly, we can really miss out.

Turner Thank you. Certainly, as a member of the technical advisory group and in my role with the Immunisation Advisory Centre, I’m certainly advising the Government on the unfolding story around waning immunity. I think what is written in the public press is a little different from what we are hearing through the scientific literature coming through. I would particularly caution against the situation in Israel. Many people may not be aware that Israel initially got very high vaccination coverage but has stalled at around about 60 percent currently, or something of that order. So still the major problem for Israel and most countries is unvaccinated. So, yes, we are starting to see a bit of waning vaccine immunity in those that have been vaccinated for the longest. Most of those are within the severely immunocompromised groups, which are actually very small groups of people. Those people are likely to be the highest need for boosting initially.

Now, at this stage within the current New Zealand context, right now today, the priority we feel remains to be on vaccinating all the population as quickly as possible with at least one dose. That will reduce significantly the most amount of death, dying, and hospitalisations. We will all be watching very closely, and I will assume that in the not-too-distant future, particularly immunocompromised people first will likely need a booster. Eventually probably others, and the data is accumulating rapidly. So we’re certainly watching this space really closely. In terms of the Government’s supplies, I think that’s a little bit outside my brief.

Seymour Yeah, sure, but just to be clear, this is a really big piece of information. You’re saying that your advice to Government is that vaccine fade is not a real thing, outside potentially some immunocompromised groups, and that, actually, they should be a lot more relaxed about vaccine fade and booster shots than perhaps most of the public narrative suggests.

Turner No, that’s not what I’m saying. What I’m saying is you expect, with most vaccines, you do get waning immunity over time. The question is when that occurs. What I am saying is the early data coming through would suggest that some immunocompromised people are those who are likely to see waning immunity first, and are the groups we need to focus on first. We do not have an answer yet as to if and when we see waning immunity for the bulk of the population, and when boosters will be required. We do not have the science answers for that yet. We’re expecting, at some stage, we will need boosting, but we do not know yet when. The only group we are particularly concerned about in the immediate future are immunocompromised.

Seymour OK, well, Madam Chair, if I could continue with a question to Professor Skegg. Professor Skegg, I’m really pleased to see, and I was thrilled when you were appointed around four months ago, and it’s really great to hear that you have been completely independent, and all your advice is released publicly, but so far, with respect, we’ve only seen 18 pages—three letters you released to Dr Verrall. I just wonder, is there more in the pipeline? Should we be expecting more reports from you to be released soon?

Skegg Well, thanks, Mr Seymour. I noticed you made a comment like that “in the public arena”, and it reminded me of I think it was Voltaire who wrote someone a letter and then he apologised at the end of the letter. He said, “I apologise for writing such a long letter. I didn’t have time to write a shorter one.” We tried to make our reports accessible to people. As I’d said, I have briefed Ministers in detail, but we’ve worked very hard, and if people wish our reports were longer I apologise, but that’s the substance of our advice, and we expect to continue to be working in the months ahead. It’s a rapidly changing situation, and it would not be possible for us to spell out in detail what will happen next year. We may not even be dealing with the Delta variant in a few months’ time. Six months ago we hadn’t heard of the Delta variant.

Seymour OK. Can I just ask about the wider situation that we face, but based on what we know right now? You know, I agree with the comments you’ve made publicly that just because there’s an outbreak that you predicted would occur had occurred doesn’t mean that we should be alarmed or spooked. But I do wonder if anything in the last two weeks has surprised you. For example, it appears that the contact tracing the Government’s currently capable of is going to take a couple of weeks to get on top of an outbreak under alert level 4 conditions. Now, if that’s the case, does that mean that for the foreseeable future that the only way that we can maintain elimination is by locking down, sort of, two weeks - plus at a time?

Skegg Well, I wouldn’t say we’ve learnt a lot in the last two weeks, except that it’s clear that New Zealand does need to strengthen its public health units and its contact tracing capacity, and that was one of the recommendations we made—that there should be a review and probably strengthening of this, and other groups have given the same advice. And I think the huge pressure—I think the people dealing with this outbreak must be working, you know, night and day. It’s turning out to be a major challenge. But I don’t think that in itself has affected our assessment of the feasibility of elimination.

But if I said the last two months, there has been new evidence that makes us more concerned. And that was particularly the evidence from Guangdong in China just last month which showed that the Delta variant is not only much more transmissible than the earlier variants of the virus, but also that the period of time from when someone gets exposed to an infected person and then becomes infectious themselves is, on average, about two days shorter. And that makes controlling outbreaks caused by the Delta variant more difficult to control by testing and contact tracing alone. So I think that does make us less optimistic that next year we’ll be able to continue the elimination of outbreaks by testing and contact tracing alone. The task has just got harder. The virus has evolved in a way that makes it more difficult to control, and that’s just an example.

Seymour Look, I have so many questions for you, but I suspect I’ll run out of the chair’s patience, so maybe you’ll get to come back later. I just wondered if I could ask you a quick question just about the incident at Highbrook, where allegedly five out of about 700 people were given saline solution instead of a Pfizer vaccine. I just wonder, have you been asked for or given any advice about whether those people should have just had serology testing to find out if they were indeed vaccinated? Would that have worked, in your view? Were you asked for or did you give any advice along those lines? And, if so, when was that advice given?

Skegg Yeah. Our group hasn’t been asked. In fact, I first heard about it in the media, as you did, but Dr Turner might want to comment.

Seymour Yeah, sorry. The questions were for Dr Turner.

Turner Oh, yep. My organisation was asked to give advice. I can’t tell you exactly what date we have as a string of advice has been given. And we certainly recommended informing all the people in the incident. I would have to say, in terms of—oh, I’m so sorry, what was the question you asked me? I apologise, I just—

Seymour Oh, the basic question was that, you know, the Minister of Health—

Turner Oh, I’m sorry, David. I’ve just remembered—serology. Yeah. I got distracted. The problem with serology is it’s not straightforward, and possibly anything up to around 30 percent of serology tests may be falsely negative, and the positives are hard to interpret anyway. So there’s not a simple answer to just doing a serology test on everybody who’s been vaccinated to see if they responded to the vaccine. So serology isn’t a straightforward answer, and certainly has been a discussion in our circles over this time.

Seymour So just to be clear, you were asked in relation to that Highbrook outbreak if the people should be serology tested and potentially sent back for another vaccination if negative, and your advice is that, unfortunately, serology testing is not accurate enough to achieve that.

Turner That is only one part of the overall advice that was given, but serology, yes, is inaccurate to give you a full answer alone, and so serology probably doesn’t have a key part to play in this. It’s a very difficult tool to use in this context. It’s not straightforward

Seymour Based on the advice you’ve given, what have you advised they do next, if you said there was quite a lot of advice given?

Turner My understanding is this was with the Ministry of Health, and I think you should take this question up with the Ministry of Health.

Seymour I was asking—

Craig David, thank you, that’s time up.

Seymour Fair enough. Thank you, Madam Chair.

Ngarewa-Packer Tēnā korua. We’ve got concerns with equity and specifically the under-vaccination of Māori, and although the vax rate numbers are showing as improving and going up, the gap between Māori and the rest of New Zealand has widened. So the stats that we’ve seen lately is 30.9 percent Māori have one vax compared to 57.4 percent of the rest of the New Zealand, and proportionally over the last two weeks it has widened to 0.4, nearly 0.6 percent proportionally to the rest of New Zealand. What are your thoughts about the under-vaccination of Māori? More specifically, what is the advice to the Government and what does the public health unit need to do to address this?

Skegg Kia ora. Just two comments, and I’ll ask Nikki Turner to comment as well. First of all, it is a bit misleading to look at the crude rates of vaccination because they’re not adjusted for age. And, as you’ll know, the Māori population on average is a good deal younger than the non-Māori population. That’s partly because of a lower life expectancy, but it’s more importantly because Māori people have had a higher birth rate in recent decades. So there are a lot more young Māori people. What I’d heard the director-general say just in the last few days is that when you compare age group by age group the Māori rate is quite similar to the rate in non-Māori, but Nikki Turner might want to comment on that. I certainly haven’t heard—and you said that it’s actually widening, Debbie, in the last week or two—the gap?

Ngarewa-Packer In the last two weeks the stats certainly show that there are more non-Māori than Māori being vaccinated, and in fact the surge vaccination programmes aren’t landing, in fact aren’t narrowing the gap of young vaccinated Māori.

Skegg Well, certainly our group have advocated that there should be particular care taken to ensure that the vaccination roll-out is done in a way that ensures that there are no groups left out, and that goes for different ethnic groups, such as Māori and Pasifika. It also goes for particular regional subgroups. And one of the points we made—and Nikki Turner’s already referred to that R0 figure that everyone’s been talking about for the last year or two. It’s not just that you don’t want groups that have got a lower vaccination coverage. There are some groups in the community who actually need to have a higher vaccination coverage to achieve the same degree of community protection. And if you take, for example, a group that are in focus right now—Pasifika people living in South Auckland—many of them live in quite crowded housing. They attend events like big church services, and that means they’re actually more at risk of encountering the virus and passing it on than someone like me, for example, who lives in a different social grouping. So it is going to be really critical for all New Zealanders that we take advice from different communities such as iwi and Pasifika and follow their guidance as to how we can most effectively get this vaccine to people.

Turner Debbie, just to add to that, I totally support your concerns. I think we have this at every level of our system, deep concerns that we need to be able to deliver and support effectively. Māori communities and Pasifika communities in particular, but also lots of our other communities like our disability sector as well, need to be supported as rapidly and urgently as we can. So all I can say from our end of the sector is that we’re putting all efforts we can into support and hear the voices of Māori, Pasifika communities, disability communities, and those others who feel that they’re not being responded to appropriately. Our system needs to continue to review and review and review and look at how we can be as responsive and supportive as we can. This is a systems issue and we must review it on a daily basis. It remains urgent and top priority. So kia ora.

Ngarewa-Packer Kia ora. Just to follow up on the equity concerns, was there advice given to the Government on a way forward in addressing—and I think you mentioned as well, David, the youth profile for us as Māori. I think 31 percent—don’t quote me on these stats, by the way—of Māori are under 20 and maybe 70-something percent of Māori are under 40. So you compare that with the vaccine strategy that’s been applied, which is very age specific. If we’ve got a young population and this vaccine gap for young Māori, is it then that we can expect that this a highly vulnerable—and I don’t want to put the fear up, because we’re already sitting in fear enough. But is there a thinking, a strategy, advice given to the public health unit, the Ministry of Health, on how we target that and that particular vulnerability in this round, the next round, or the other 500 rounds, I’ve got to say, coming up? Is there a view from your thinking, I guess, is what I’m seeking, and you as well, Nikki, please? Yeah.

Skegg Our group hasn’t been directly involved—the group that I chair—in advising on the vaccine roll-out, but Nikki Turner is on another group that is, so I’ll pass this to Nikki.

Ngarewa-Packer Oh, great. Thank you.

Turner So I was a member of what’s called the IIAG group, the implementation advisory group to the Ministry of Health. I have stood down off that group because I’m also on the technical advisory group and now this one. But that group’s focus—and strong focus and key focus—was about the Māori voice and the Māori communities and being heard in the equity gap, and alongside the Pacific and the disability sector. So I would refer you back to the recommendations advice being put through to the ministry from that group. I think they had a very strong voice, is strongly Māori- and Pacific-focused.

The age issue is a tricky one, because, as we know, the problem with this virus is that older people die in way, way higher rates, and people with medical problems. So the focus needs to be on that, and we are very aware, from our flu vaccination programme, that elderly Māori miss out, and we put effort last year into innovative ways in Māori communities for delivering flu vaccination more responsively with Māori communities, and did get some success.

So I do highlight that with a lot of effort and focus, we can make a difference, and we actually did a lot better last year with flu vaccination for older Māori people. So I think we have got lessons that we are learning and need to continue to learn.

Ngarewa-Packer Thank you. Just one last—through the Chair—well, I missed [*Inaudible*] With the modelling that you spoke to—that we should or shouldn’t take heed of, but actually we do—has there been some advice or consideration on the modelling on the health system’s current capacity, or required capacity, to deal and address equity in large communities or in a large event outbreak?

Skegg Well, there hasn’t been a lot of modelling done on the capacity of the health system that I’m aware of, and that’s something that we have really called for, because New Zealand is really vulnerable. Quite apart from equity considerations, just in general, we are not well placed to deal with any substantial outbreak of COVID-19.

As you will know, our health system is stretched most of the time, and when one starts to look at things like intensive care beds and so on, we are way below the average for the OECD. So that is one of the incentives for us to try—it’s one of many incentives for us to try—and keep COVID-19 as low as possible.

Williams Thank you, Liz, and thank you Drs Turner and Skegg. My questions are following on from Debbie’s concerns about equity—and thank you to my colleagues for indulging this in time, because I do think there is a lot of public interest in getting this right.

A couple of weeks ago, the Government announced that the time between doses of the COVID-19 vaccine would increase to six weeks. From where I’m sitting in South Auckland, that affects a lot of people here who are in those earlier groups, whether they were MIQ workers, but particularly here I’m thinking about Māori and Pacific people. Dr Skegg, Dr Turner, can you give some advice to Māori and Pacific people who may have been in, say, group 2 and 3, about whether they should be concerned if they had, say, a three-week gap?

Skegg Well, I’ll pass that on to Nikki. I’ll just say my ones were 21 days apart and I’m certainly not worrying. But I’ll pass it to Nikki to talk about the evidence.

Turner Yeah, kia ora, David. I was 21 days apart, too. So, firstly, to reassure people, you know, this vaccine was designed and went through its clinical trials with the 21-day gap, and that’s effective. But what the accumulating data is showing, and beginning to show more and more, is that we might get a longer duration of effectiveness if we have a longer gap. So that countries overseas are suggesting—and it’s back to the original question about potential for waning immunity—that we will do better with a longer gap. And particularly for younger people, who have a very strong and vigorous immune response to the first dose, a six-week gap is very useful, and there is also the potential that the longer gap—they may actually get less vaccine side effects with the longer gap than a shortened gap.

So what I want to say is, there is nothing wrong with a 3-week gap, but there is a potential gain in having a 6-week gap. Alongside that, the advantage of a six-week gap is we want to get out there fast and give as many people as possible the first dose. So it’s a bit of a trade-off. If we can get as many people as possible the first dose, we do know that one dose does reduce severity significantly. So it will reduce severe disease even if we continue to get transmission. And, really, in the end, our priority is in case we do get community transmission, we want as many people as possible protected against severe disease. So I think, overall, with the balancing of all these different scientific issues, the gain in getting one dose into people is considerable at this point.

Williams And just on that, so in terms of protection of the partial dose or the first dose, for those, say, 88,000 people who got that done yesterday, can they not only expect to have less impact of the disease on them but how does that affect the transmissibility if they were spreading that?

Turner Yeah, so it is more effective against severe disease. So the first thing is, within a week or two weeks they will have pretty good protection against severe disease. They can still transmit it. It is at lower rates than completely unvaccinated, but, obviously, we would in the long term prefer two doses, which will also reduce transmissibility more. But one dose is way better than none, which is our point.

Kerekere Kia ora. Thank you. Tēnā rā kōrua. I really appreciate your succinct reports. When I read through and I thought, “Oh, is this the executive summary?” and then I realised it was the whole thing, I was so happy. I like to know what is the guts of it, so kia ora. Two things I wanted to raise was about advice to Government. We, as Māori and Pasifika, are told constantly are we aware of the significant health disparities that we face, and of course in relation to all of the other disparities, which is the natural event of colonisation. When Te Rōpū Whakakaupapa Urutā was established as one of the many people who are providing advice, they did actually say that if you wanted to help protect Māori, then age phasing-in applying also to Māori was not a good idea and they shouldn’t do that. So the Minister has confirmed that they decided not to take that advice. I just wonder, is there something in what you’ve seen and the ways that strategies have pulled out—is there clear evidence that where Māori are in charge of a Māori response for Māori communities—and likewise, I’m gathering, for Pasifika—that those Māori populations probably do better?

Skegg Well, that’s, I think, an important general principle for people, and, you know, the more that people can determine their own healthcare the better. That applies to Māori and Pasifika. It applies to other groups as well. In terms of vaccination policy, there’s been a lot of debate around the world as to whether you should focus first on the people who are most at risk of severe complications, and, as Nikki Turner said, older people and people with underlying health problems like diabetes, hypertension, and obesity are the most at risk.

But then if you’re wanting just to control the spread of the infection in the community, you might focus more on younger people, because they’re the ones that are mixing the most, and we’re seeing that at the moment with our current outbreak. It’s young people who tend to mix the most and may drive an outbreak or an epidemic. And in Australia, the Doherty Institute have actually recommended that they should now focus on younger adults in their vaccination programme. I guess our—as I said already, our group hasn’t been involved in the vaccination planning at all. I guess what we want is just to get as many people vaccinated by the end of the year as possible, and obviously to try and avoid outbreaks like the one we’re having. And it won’t matter too much who gets it first. What really matters is where we end up.

KerekereThank you.

Turner The only thing I’d add to that, David, is the system science would say that the best working system is a system that works with its community, communicates well with its community, but is also a high-performing, effective system. So it’s all the different bits of the system working well together, which is what could give good and effective and high coverage for any community. Kia ora.

Kerekere Kia ora. And so that just brings me to my second question about your suggestions about improving our public health system. I’ve been a bit conflicted. I’m totally on board in support of what our Government is doing—totally support an elimination strategy. What I’ve found hard is that all this effort has gone in to make sure people don’t die from COVID, but our people are already dying from everything else. And so I have struggled that none of this effort has gone into doing what needs to be done to stop our people dying in all the other areas that we do. And so, I suppose, if you were going to say, what are two or three things that must happen in our public health system that’s going to make it easier to deal with this pandemic, which is not going away apparently any time soon? Yeah, I suppose, what are—you mention it but don’t go into much detail in your letters. What would you suggest?

Skegg Well, I guess the most important point is that by controlling COVID-19 and indeed by keeping it out, we’ve managed to maintain our health system functioning in its normal way, which is quite rare around the world. I mean, in countries like the UK there’s a huge backlog now of people who’ve had their cancer treatment delayed because of what’s happened in the last 18 months. New Zealand’s a very rare country, because if you look at all the countries in the world and look at their excess mortality over the last year—and that’s from all causes—you see quite an interesting rank order. But New Zealand kind of sticks out because we go in the opposite direction. We’ve had a deficit of mortality in the last 18 months, and that’s because not only have we had a very small number of deaths from COVID-19 but also, because of the way we’ve been behaving and with the lockdown and with the border restrictions and so on, there have been fewer deaths than normal from other causes. So I think it’s really important that we do keep COVID-19 under control, but beyond that you make a really important point. There are many other health problems that New Zealand has, and, as David Seymour and others know, I’ve been rabbiting on about this for years, and, you know, we do have to do a lot about issues like smoking and obesity, which are causing so much poor health in New Zealand. And it’s not just a matter of public health—the preventive things, which are obviously my field—but also I believe our whole health system needs more investment. And I think we see it’s under a lot of stress at the moment, even without any significant problems from the pandemic. So I think, as New Zealanders, we have to all accept that we need to invest more in our health system.

Kerekere Wonderful, thank you.

Seymour Dr Skegg—Professor Skegg, sorry, Elizabeth Kerekere’s question, I think, is a good one. You know, people die of other things. It seems to me that just about every society has been prepared to spend a lot more to save a quality-adjusted life-year from COVID than we have been from other things that harm people, including some of those causes you mentioned that you’ve championed over the years. I just wonder if you’ve been asked for or done any work on the cost of COVID measures in terms of quality-adjusted life years vis-à-vis what we’re prepared to spend on, say, cancer drugs or, you know, road safety improvements, or other things where our society frequently has to make that decision.

Skegg No, we haven’t done work on that, but, of course, societies react very differently to a problem like COVID, that actually closes the whole place down and closes the hospitals down. I mean, we’ve all seen what happened in the United States and the UK and so on. So, unfortunately, we become quite tolerant of people dying every week from road accidents or lung cancer or anything else, because we’re used to it. But COVID-19 is an example, and it’s true of pandemics and other epidemics of infectious disease—it affects everybody. It affects the economy. It all just grinds to a halt. So it’s not surprising that Governments pull out all the stops and spend a lot more money all of a sudden, because otherwise, you know, everything goes to ruin.

Reti Thank you, David, Nikki. Good to see you. Thank you for joining us. I’m interested to know how does the plan you outlined before the current outbreak change with what we now know? Are your assumptions still fundamentally valid? So, for example, day one or day two, there were some modelling expectations—not in your hands but in others—that we might have 50 to 120 cases, and those assumptions now have clearly failed. So I’m interested to know, with what we know now, what of your recommendations or assumptions change from the plan as you mapped it out?

Skegg Well, as I say, I don’t think what’s happened in this current outbreak has changed our plans at all. And I hate to sound like a terrible sceptic about models, but I think those estimates in the first day or two—you know, it’s very hard for anyone to model an outbreak with such limited data. So I don’t blame the modellers at all, but it will take some time to see how long this outbreak takes to stamp out.

So I don’t think the advice that we gave in our second report has been changed, but as I said to David Seymour, I think the one thing that makes us more cautious is what we’ve learnt in the last, just, basically, a month ago from Guangdong in China. We’ve seen it played out now in places like New South Wales—over 1,000 new cases today. They’ve got over 100 people in intensive care. And, of course, they acted too slowly. Their lockdown hasn’t been as rigorous as ours. But I think we’re still seeing something really quite different from what we’d experienced with the earlier variants. So, at the moment, I don’t see anything which would make us alter the various steps we’ve suggested, but it certainly makes me feel more cautious.

Reti Thank you. Your reports indicate—which would seem self-evident—that primary care is critical to the response. How do you respond to officials yesterday telling us that it will take months to on-board primary care—that’s GPs and pharmacists?

Skegg I think Nikki Turner’s probably—

Turner Yes, I can answer that. There are already quite a few primary care and pharmacists on-boarding already. So the country’s got a mixed model of clinics all round the country, between Māori and Pasifika providers, big mass models, and general practice and pharmacy. You’ll be aware, Shane, that there was a delay at the start because of the nature of the Pfizer vaccine, with it having to have the ultra-cold temperature storage. So in the early days we were slow to bring on primary care to that, and it’s really been since the updating in the cold chain advice that primary care is getting more experience with being able to manage and take on board this vaccine. I think we are going to see rapidly more primary care coming on board.

I have to say, as a primary care provider, it is still a very difficult vaccine to manage. It’s not quite as straightforward as some of our traditional vaccines. So there are some logistical issues, particularly for small general practices and particularly for small pharmacies coming on board. But we intend and are certainly trying to grow that as rapidly as we can, recognising at the same time that general practices now are also really squeezed with all the other issues going on. So it is a bit of a balancing feat. Certainly, we’re very supportive of bringing on general practice safely and as effectively and efficiently as we can, and pharmacy as well.

Reti So the Medsafe change to the cold chain regulations were 28 May—that’s sort of quite a while ago. I would’ve thought we could’ve moved quicker, but I understand that’s not a you problem. I’m interested to know, had colleagues from Canterbury who were concerned clinicians—that they received documentation saying they needed to return to work, that they shouldn’t complete their administrative—that is, their non - patient-touching/facing tasks—remotely from their homes, that they should be returning back to work. Do you believe that’s a safe practice?

Turner I’m unaware of this, sorry. I don’t know what Canterbury DHB has been advising. What—

Reti What would be your view, then, for our clinicians completing administrative, non - patient-touching work being instructed that they should return back to their clinical workplace and work from there under level 4?

Turner Are you saying clinicians who are choosing not to go back face to—

Skegg No—actually, I saw this, Shane, and, like you, I was concerned about it. It seemed very odd to me that people were being ordered to go back to work to do things which they could do safely from home, and I would imagine whoever wrote those emails may be regretting them now.

Turner It doesn’t quite make sense.

Reti It doesn’t make sense, does it? My last question would be: David, you’ve been a strong—and I’m sure you have too, Nikki—advocate for Bluetooth technology. We’re hearing nothing in this outbreak. Do you have any sense of the role it is playing, and, in your view, what role should it play?

Skegg Well, as you’ll have noticed in our reports, we have been concerned about the very low use of the COVID app in general, quite apart from the Bluetooth technology, and I’m sure everyone on this call will have had the same experience as I have. I try and scan in wherever I go, and I always seem to be the only person doing it, as I walk into a shop or a supermarket. And I think that’s been one of our real problems, actually, in New Zealand, has been complacency, and I guess this outbreak will have shattered that for a time. But that’s why we recommended that scanning of QR codes should be mandated at some types of venue. And I know it’s not a straightforward decision, that, but the use has been so low.

When it comes to the Bluetooth technology, that’s of course even lower—the number of people who have that switched on—and so far it’s been of very little value because you need both parties to be using it. But that’s the kind of thing I think we’re going to need to really lift our game on in the months ahead if we’re going to be able to be reopening our borders but also enjoy the kind of life that we have been over the last 18 months. So, yeah, I think it needs a lot more work.

Reti Yeah, agree with you. Thank you.

Pallett Thank you, Madam Chair. Thank you, Professor Skegg and Dr Turner, for being here. It’s fascinating. Thank you for sharing and giving us your time. So my question might be directed best to Dr Turner because it relates to the vaccine, and it’s really around our choice to go with Pfizer. Now, I know that we all realise that choosing Pfizer was going to result in us having a roll-out that was focused more strongly on the end of year and we’re committed to the whole year roll-out, but could you just explain to me a little bit more about the rationale and why we would’ve made that choice?

Turner Well, I think that, obviously, late last year, we made a choice to consider four, in general, with the advance purchase agreements. What we saw from the clinical data coming through last year and the data coming through this year that Pfizer was a highly performing vaccine, and, in fact, the data has just continued to accumulate that it is one of the best performing, if not the best performing, vaccine in the world. It’s really up there. So I think in terms of clinical scientific evidence, we have got, if not one of the best, the best vaccine in the world. So in terms of offering our population the best we can, the highest protection, that’s a really strong reason for going just with Pfizer. Obviously, the supply issues are all about the Government and the ministry and how they can secure those, but from my clinical, scientific evidence, New Zealand has done us proud by going with the Pfizer vaccine.

Now, I think it’s a really interesting question, looking forward into the future, as you look at schedules and vaccine schedules. We’ve discussed about the interval timing and, as the data accumulates, how that might shift. Also, data will continue to accumulate on what might be the best schedule going forward into the future, and there is data accumulating about mixed schedules.

Now, that is still pretty early science at this stage. Right now, this year, we’ve got real scientific confidence that a two-dose Pfizer vaccine is the best out there on the world market, but we need to watch this space. We may well be interested in moving forward in other brands as well. There is also a very, very small group of people who cannot take the Pfizer vaccine. So there is a very small group of people in New Zealand where we will need to access another vaccine for, which is likely to be the Janssen later in the year.

Pallett Well, thank you for that, because, actually, my supplementary to that was really with regard to the Medsafe approval of the Janssen and AstraZeneca vaccines. And I just wondered if you could expand a little bit more about the factors that we might take into account if we are considering whether to include them in our vaccination programmes.

Turner Yeah, so there is a very small group of people who have a contraindication to the Pfizer. This is, essentially, people who have had a severe allergic reaction, anaphylaxis, to the first dose of Pfizer. Those are the people that we would not recommend a second Pfizer to, so there’s an advantage in having a small supply of a different alternative safe, effective vaccine. Both Janssen and the AstraZeneca have been approved by Medsafe, so that’s the role. Going forward into the future, if and when we look at boosters, then there’s a role to look at the different mix and match we have amongst the vaccines and what would be the most effective for New Zealand. So this is, you know, ongoing science, and I’m happy to have this conversation as we learn it over the next few months.

Pallett Certainly evolving. Listen, thank you very much.

Turner Thank you.

Watts Yeah, thanks very much. Look, question for Professor Skegg—and I’ve got two—look, the official guidance for the current lockdown in Auckland is obviously a time frame until next Tuesday. Based on the current trend numbers, when do you foresee a meaningful easing of restrictions?

Skegg Well, I said that I’m not able to talk about the current outbreak with any great wisdom because I don’t have any information that you don’t have, but as an uninformed person I would say it’s most unlikely the lockdown will end next Tuesday. It’s clearly going to be a matter of some weeks, I fear.

Watts OK, and the second one is: you noted in your opening remarks that this outbreak was predictable. So do you think that we were adequately prepared, and, if not, what areas could we have done better in retrospect?

Skegg Yeah, well, first of all, the reason I think it was predictable is that no system is perfect, and people kept saying to me, “Oh, well, we haven’t got COVID.” We have had COVID; we’ve had Delta in the country for weeks, if not months. We’ve had it in at least three hospitals. We’ve had it at MIQ facilities. Sooner or later, however hard you try to have a perfect system, things go wrong. So it was inevitable that Delta would come into the country.

I do believe the Government was preparing for this. Every second Tuesday, as chair of this committee, I get invited to sit in on the first part of a meeting of the heads of all the Government departments and ministries that is chaired by the head of DPMC, Brook Barrington, and they have been talking for a long time about preparing for a Delta outbreak. So it didn’t come out of the blue. It wasn’t as if they weren’t expecting it.

So I think there was a lot of preparation done, but was everything done that could’ve been? Well, of course not. You know, it’s like everything. If we have an earthquake tonight, my household won’t be as well prepared as I’d like to be. This was a predictable event, and, you know, I’m sure that when it’s all over, people will look back and think—and I hope we’ll learn from the experience—about things like our contact tracing capacity. But I do think that it was expected. Obviously, people hoped it wouldn’t happen, but it has.

Watts So, based on what we talked about before around vaccination levels, you mentioned around 90 percent but the reality is as high as possible—and I think the press have reported today December is sort of the time line—is the reality that we should expect, sort of, the deployment of lockdowns until we get to that point where our vaccination levels are at that level of appropriateness? Would that be reasonable?

Skegg Yes, if we have an outbreak—if we have another outbreak of the Delta variant in the coming months, I think it’s inevitable that we would have another lockdown. Obviously, I hope we won’t. I mean, we have gone for just under six months without a single outbreak. Obviously, I hope that this one is stamped out quite quickly and that that’s the last one we have, but only time will tell.

Watts OK, and just the last question, Professor Skegg: look, I’m interested in your views on how our elimination strategy can be pursued long term. You mentioned at the start, you know, we’ll review at the start of next year, but can you give us a little bit of—you know, what planning have you done for that next phase?

Skegg Yeah, we’ve had a lot of discussion about this, but, again, I have to emphasise, it’s very hard to plan six months ahead with this virus. I’m actually on an International Science Council panel with­ Sir Peter Gluckman, and we’re looking at—it’s a group of people from all over the world looking at future scenarios for the COVID-19 pandemic. And there’s so much uncertainty as to how this pandemic is going to evolve. And there’s a very distinguished scientist from South Africa who made a comment at one of our Zoom meetings—he said, “A year with another disease is a month with COVID-19.”; in other words, it’s changing so quickly.

So, you know, I’m sure that we will need to revise our strategy, whether it’s still called an elimination strategy—by the way, our group don’t like that word. We actually recommended that there should be a different name for New Zealand’s approach to dealing with COVID-19. No one showed any interest in that recommendation. But it’s just an example of how we don’t think elimination is a very good word. It confuses people. It doesn’t mean eradication. But I’m sure that the strategy will have to be revised. But that can only really be done closer to the time, when we know what variants we’re dealing with; when we know more about the issues about the vaccine, some of which have been brought up this afternoon about, for example, waning of immunity, the extent to which the vaccines prevent transmission of infection as opposed to preventing severe admission and death, for which we know they’re extremely good; and we’ll have new tests. We may even have antiviral treatment on the horizon, and that could really change our approach to this disease.

And, also, I hope that in the future we may have better vaccines. The vaccines are fantastic, but it would be even better if we had vaccines that reliably prevented people from passing the infection on to others. So, you know, it’s a kind of question of “watch this space.” I’m sorry to appear to be ducking your question, but I think it would be really quite silly for me to say what we’re likely to be doing in that space next year.

Seymour Professor Skegg, I just wondered if I could ask about the idea of the vaccine roll-out being completed. It’s throughout your letters, and it seems to me that your basic strategy is to complete the vaccine roll-out, then other things become possible. But I just wonder if you could define what “completing the vaccine roll-out” means? You’re reluctant to give a specific percentage. So how will we be able to tell if the vaccine roll-out is completed?

Skegg Well, we chose those words deliberately because we weren’t thinking about a particular percentage. If you wanted one, I’d give you 100 percent. But—

Seymour Well, you also say that’s unrealistic.

Skegg Yeah, unfortunately. But it was really a logistical criterion that everyone has had a chance to be vaccinated. Obviously, we hope that a very high proportion of people will take up the vaccine. And by the way, one of the—you know, no one would’ve wished to have this outbreak, but I think it will have reminded people that this is an ever-present threat. So I’d hope it will increase the vaccine uptake.

But what we were thinking was—our group only gives advice about the health aspects of this pandemic based on the scientific evidence. We accept that the Government is going to have to consider all the other considerations: social, economic, and so on. If you asked us “What’s the safest thing we could do for New Zealand’s health?”, I would say, “Keep the borders completely closed.” I mean, if health was our only criterion, that’s what we would do. I know you could well mount arguments about the effects on the economy and, therefore, on health and so on. But we are assuming that New Zealand is going to reopen. We cannot stay cut off from the world indefinitely. So we are acting on the assumption that once everyone has had a chance to be vaccinated, the Government is going to start reopening the border in a staged way. And I think there would be, I imagine, a political consensus about that. So—

Seymour So can we take from that—what you’re really saying is “complete the vaccination programme” means everyone who wants one’s had an opportunity and had one.

Skegg Yes. Of course, there is the issue about the lower age bound, which is, you know, under discussion at the moment.

Seymour Sure. Can I just ask—I’m sorry, were you still going?

Skegg No, not at the moment.

Bishop Can I ask a supplementary on that, David?

Seymour Yeah, of course. Go, Chris.

Bishop Because it was going to be—and it follows on from what I was going to ask anyway, which is it’s a really interesting question, or really interesting comment, Professor, around—you’re assuming that we will reopen. I suppose the question is this—and this is what I’ve been grappling with over the last month or so, or last two weeks in particular—say everyone gets offered the chance to have a vaccine by the end of the year, and we get to 31 December and 68 percent of people 12-plus have been doubly vaccinated. Would you still advise the Government to proceed with partial reopening of the borders, as they’ve outlined, in the first quarter of next year?

Skegg Well, as they say, that’s a hypothetical question, because I’d be very disappointed if it’s only 68 percent.

Bishop But the reason I ask that is that is a realistic possibility, you know? That’s why the numbers matter.

Skegg Well, they do, but, you see, we don’t decide. I mean, we advise on what precautions need to be taken. It is not up to our committee to say whether the borders should be open or not. What we are urging our fellow New Zealanders: please get vaccinated, for your own sake and for the sake of your family and your whānau and your community. At the end of the day, it’s the New Zealand public who will make that decision, Chris. They will decide whether they get vaccinated, and they will decide, politically, whether they want to open the borders. And no doubt your party and every party will be polling people to find out whether they want the borders open. It won’t depend on us.

Bishop I appreciate that, but, you know, unfortunately—or this is just the reality—your three letters to Dr Verrall have been linked in the public consciousness, and, in fact, by the Government, to be honest, to the reopening of New Zealand and the loosening at the border. You know, the letters were released a day before the reopening to the world symposium, which you spoke at. And paragraph 12 of your last letter says, “Our expectation is that, with all the precautions outlined in our previous letter, the scheme would lead to relatively few incursions of the virus and that these could be stamped out quickly.” Now, that reads to me like, basically, a form of advice to the Government around how to reopen safely. So my question is, really: is it safe to reopen, as outlined by the Government, with only a 68 or 69 or 70 percent vaccination coverage?

Skegg Well, when we wrote that letter we assumed that we would achieve a considerably higher coverage than that. But let me be completely frank: when we reopen the border, things are going to get tough. I keep saying to my friends, this is the golden year. We’ve had a wonderful time the last six months. We’re almost the only country on earth just living a normal life. I know some people have been really impacted by the border closures—obviously, families that can’t be reunited, people who work in tourism. You know, I know some of these people, and they’re suffering. But most New Zealanders have been able to enjoy normal social life. Our economy is doing well. I think this is—you know, many people sort of saying, “What we’ve been through”—we’ve spent less time in lockdown than other developed countries. But I think things will get more difficult. When we start reopening the borders, we’re going to have outbreaks of COVID-19, and they may be difficult to control. And we obviously want to avoid having lockdowns, so I think we all need to be aware of that: that this virus is not going away, and, unfortunately, we’re going to be in a war with this virus for years. And—

Seymour Can I just come back in—oh, sorry—

Craig That’s fine. Come back to your—because yeah, it was a supp, so David, back to you.

Seymour Very generous there. Look, I just wondered about that, following on. Do you believe that what other countries do is important to New Zealand’s decision-making? Because I see the Prime Minister of Australia being quite aggressive about the abandonment of elimination, even saying New Zealand’s living in a cave. I mean, it seems to me we could end up with China, a country that we have some things in common with but some very stark differences with, and New Zealand being almost the only remaining elimination countries. And you said in your presentation our problem is we’ve been abandoned by our allies, but to what extent do we have to have different strategies or scenarios depending on what other countries do, particularly Australia?

Skegg Yeah, well, that’s a really good point, thank you. Yes, I did say our allies have let us down, by which I meant the rest of the world, really. And the independent panel chaired by Helen Clark really highlighted how the World Health Organization didn’t provide the leadership needed. The human family could’ve done so much better with this pandemic, you know, 18 months ago, and it does make it much more difficult for us. The ideas we had about an expanding bubble with Australia and more and more countries just are no longer realistic.

But going back to the comment you made about Australia in particular, which, obviously, is our closest neighbour and our most important ally, I thought the comments from Scott Morrison were pretty inappropriate but very much stated in his own political context. By the way, Mr Morrison has never supported elimination. It was the state Premiers who actually ensured that Australia did eliminate COVID-19. But I’ve got somewhere here—I just—

Seymour I should add, he is an Australian, too.

Skegg Yeah, well, he is, and my general reaction when I heard his comments about us living in a cave, I thought, well, I know we were involved in the negotiations for Federation in 1901 but we decided not to become part of the Commonwealth of Australia, and at least that means we can choose our own destiny. And maybe some of the other states like Queensland, South Australia, Western Australia, and Tasmania are having the same thoughts at the moment. But right back in July 2020, he said it was impossible to achieve elimination, which obviously wasn’t true, and that trying to eliminate the virus was not the right strategy for Australia. And I’ve watched Mr Morrison’s press conferences over the months, and one thing I find really interesting: when New Zealand’s doing better than Australia, which has been a lot of the time, we may as well not exist. He never mentions New Zealand. In fact, he says no other country has done as well as Australia. But the minute we have a setback like this, we suddenly come into the conversation.

But I think he is clearly facing a big internal problem, that he’s got his national plan but the Premiers of several states have made it clear that they no longer want to follow that plan. And one of the problems is that it’s already been scuppered by what’s happening in New South Wales. And so I think it’s going to be very interesting to watch what happens in Australia. It may even be quite a constitutional issue, because you’ve got different states who maintain their own borders really going against the idea that the whole country will live with COVID.

Seymour Yeah, well, he’s not—

Turner Can I just interrupt—sorry [*Interruption*] Do you mind if I just go back to Chris’s question, which is [*Inaudible*] question, is we don’t know what we’re going to end up with in terms of immunisation coverage. We have confidence it’ll be high, but we don’t know the figure. We’ll do the best we can in the country, and, really, with all the best modelling and all the best international knowledge in the world, we are just going to have to take it step by step. And the recommendation from our committee is to carefully open up in little steps at a time and see how our services cope, whether we can track and trace and stamp it out or not.

So, Chris, we can’t give you a clear answer, but I think it’s really important that we don’t just lock, stock, and barrel open up but that we, you know, do a continuous quality cycle; we open up step by step and then see how our services respond and then make our response in relation to that. And it’s a really graduated approach. It’s not, you know, a clear, straightforward pathway, but it’s a step-by-step, graduated approach, because we will not know—you’re quite correct—the absolute level of immunisation coverage we’ll start from, nor will we know whether we can get homogeneity across all the community, and we’ve still got communities at high risk. So, you know, some of this will remain unknown as we move forward.

Craig Thank you, Nikki. David, just in the interests of time, I’ll hand over now to Chris Bishop to complete his primary. Thank you.

Bishop Yeah, thank you, and it follows on from David’s point, I think—and thank you, Dr Turner. I suppose the problem that we face is that there’s a disjunct between what you just said and what’s kind of been outlined by the Government, which is—anyway, I won’t get into that. But I suppose the ultimate question for both of you is: what would it take in terms of New Zealand’s—in terms of something happening in New Zealand for you to conclude that elimination is now an impossible goal? I’m not saying it is, but what would it—and I know it’s a hypothetical question, but what would you be looking for, for you to conclude, as an expert group, that elimination had now moved beyond being possible into being impossible?

Skegg Well, as Nikki Turner just explained, we will be trying to do it. We’ve emphasised that the way the term has been used in New Zealand, really since early in the pandemic, is that elimination does not necessarily mean zero COVID; it means zero tolerance for cases of COVID, so stamping it out. We will continue to try to stamp it out. When we fail—we’ve emphasised, and I said publicly on 12 August, we may fail. We’re taking an ambitious strategy, but we lose nothing by doing that. In fact, it keeps our options open. But we may find that it’s not possible. We may finally have to move to a suppression strategy. But it won’t be something—we won’t think in advance “Oh, let’s give up and let’s stop trying to live the way we are”. It’ll just happen, if it does happen. But, unfortunately, it will not be good, because we will all have to live a more restricted life. People will have to shield from each other, particularly older people, in winter. We’ll probably all have to wear masks, and a lot of people will get sick and die, and not just from COVID but also from other diseases which won’t get treated in a timely way because our health system will be so overwhelmed.

So what we’re saying is, let’s do our best. Unfortunately, the Delta variant makes things more difficult, but if we can achieve a really high vaccination coverage, we still believe we’ve got a good chance of pulling it off.

Seymour Chris, can I just ask a quick question—

Turner Can I add a little bit more to that?

Craig Back to Nikki, and then to Chris.

Turner Thanks. I think there’s a bit of a misunderstanding about the concept of herd immunity that a virus never, ever spreads in the community. But what you can get is degrees of herd immunity, and this is a realistic option going forward, is that if we do get the virus into our community, we track and trace and stamp it out as much as we can, but you still have a degree of community spread. Now, we don’t know what that will look like in New Zealand, but that is a realistic option going forward—that it will continue to spread in the community, and our public health services will adapt to the degree at which they could. We may not manage to stamp it out, but we may manage to control it in different ways, which is the next step away. And that’s what we’ll have to watch [*Inaudible*]

Bishop I understand what you’re saying. I suppose I just make the comment that that is going to be a massive psychological change for the New Zealand population. New Zealanders have become very persuaded by the idea that one case in the community is “Disaster-ville”. And, you know, I just make that point that it’s going to take quite a cultural, psychological change in our population.

I just have a couple of smaller points. Do you have any estimated effective R-value for Delta during this current lockdown? Have you done any work on that?

Skegg We haven’t seen the data on the current lockdown. But can I just comment on your previous statement. At the moment, one case of COVID is—was it “Disaster-ville” you said? I mean, we’ve seen what’s happened. In fact, our current outbreak all goes back to that one limousine driver in Sydney who was infected while he was transporting aircrew. The whole Sydney outbreak, it spilt over into Victoria, Queensland, ACT, and now New Zealand—it all comes from that one case. But, of course, if we have a really high vaccination coverage, the scenario is quite different.

Bishop If—if we do.

Turner Can I just reflect one more issue—that it is challenging for our country to live with uncertainty, and that we make the best strategy of the day, and it’s challenging for all of us to know we need to continue to live with the uncertainty around this. I really reflect what you’re saying—that, you know, it is hard for our people.

Seymour That’s something I wonder if I could ask a quick supp on, Chris?

Craig Just making sure—Chris, have you finished your primary line first?

Bishop I’ve got one more question for Dr Turner, but I’m happy for David to ask a supp.

Seymour No, well, you ask your one first [*Inaudible*]

Bishop Just very quickly, Dr Turner, it goes back to the Highbrook stuff, which is in relation to the vaccine technical advisory group. Was your committee made aware of the incident in Christchurch as well, the similar incident?

Turner I was referring to advice that was asked by the Immunisation Advisory Centre, not the technical advisory group.

Craig So this is a different capacity of terms of reference. OK, Chris—

Bishop I still want my question answered.

Craig I think that probably—

Turner I said yes, sorry. Through IMAC, not through the technical advisory group. Through the Immunisation Advisory Centre.

Bishop In relation to the Christchurch case, as well as the Highbrook one?

Turner Yes, that’s correct.

Bishop OK.

Seymour Just picking up on something Dr Turner said that I think’s really important, and if I could reflect something that a lot of people I represent have expressed in different ways: certainty is really important for a bunch of personal and commercial reasons. Now, we understand that there are real, physical problems—evolving variants, not sure about vaccine uptake—but I think what would be so helpful is if you were able to lay out alternative scenarios so that people can have a glimpse of what the future might be like, given some of that uncertainty. Because while I respect the work you’re doing and the challenges you face, to say that we can’t plan anything in six months, anything could change, we just don’t know, it doesn’t deliver the certainty that people would really crave from you.

Turner I think that’s very useful feedback, and I think we could take that back. Sorry, David—over to you.

Skegg Well, I was going to say, I mean, we have spelt out the steps we think should be followed in the first part of next year. But I would just say there’s one thing more important than certainty, and that’s honesty. Unfortunately, we do have to live with uncertainty. We all have to do it all the time, of course. I mean, no one knows whether they’re going live for many years or whether they’ll die tonight, but this is a particular situation which is so dynamic. I mean, who would’ve imagined that Sydney was in the situation it was, two months ago, or three or four months ago? No one would’ve imagined. They’ve been in lockdown now for two months, it’s going to go on for weeks or months ahead, so it’s a very difficult—I think we’ve really got to explain to people why we have to live with uncertainty with this pandemic. We have tried to spell out in some detail what steps we should be taking next year.

Seymour But if you look at the Sydney example, I mean, your own report forecast—and I don’t think it was particularly difficult to forecast, but you said it—that the Delta outbreak in Auckland would occur. You could’ve made the same forecast for Sydney; it’s just a bigger version of Auckland, one step up the global supply chain. There are things that you can say.

Turner I think there’s a difference between being certain about an outcome and what you’re suggesting, I think, which is saying that these are some other possible outcomes. I think that’s reasonable, and we’re certainly looking at that, at what the possible stages could be, but you’ve seen in other countries where they come out with certainty, and they’re certainly proved wrong in their certainty.

Seymour Yeah, and that’s why you need to lay out—

Craig David, we will just move on now, because that was a supp, but just moving on to Anae. A question from you, Anae.

Leavasa Malo le soifua maua ma le lagi e mama. Thank you, Professor and Dr Turner. Just wanted to go back to what we’ve seen overseas, and how Delta has entered our community. My question is about if you can just tell us how keeping this more infectious variant out for so long, as we did, has helped us respond effectively to it.

Skegg Well, it’s obviously had hugely beneficial effects on our way of life and our economy, but it’s almost been a problem, I think, because it has made us complacent. I think a lot of people felt we’d beaten this virus when, of course, we hadn’t; we were just keeping it out. I think that it was really necessary for people to realise that this is going to be a more difficult challenge in the time ahead. I’m not sure if I understood your question, but—

Leavasa No, no, that’s OK. Can I just follow up on that as well. Just on the threat posed by new variants in general, what are the perfect conditions, or the environment, for these new variants to emerge, and whether there’s anything we can do to prevent or prepare for an issue like that?

Skegg Yeah, well, that’s a really big global challenge, because the more replication—there’s millions of replications of this virus going on, and mutations occur all the time. There will be new variants, and if there’s one that’s more easily transmitted than Delta, it will become dominant over time. It’s completely unpredictable, and, actually, Peter Gluckman and I have had interviews with some of the leading evolutionary virologists, and they make it very clear that you can’t assume that the virus will become more or less lethal. Some people have this idea, “Oh, well, it’s bound to become, over time, more like the common cold” and so on. That really is not the case. The next variant will be more transmissible—that’s how it will displace Delta—but it may be more or less harmful to humans. And, obviously, the worst-case scenario is one that is more virulent, causes more severe illness and death, and particularly if there was one that was able to evade the vaccines. You know, there are already one or two variants that are more resistant to certain vaccines—fortunately not the Pfizer vaccine—but, obviously, the biggest concern would be if a variant were to become prevalent that was able to evade the vaccine-induced immunity. And that’s just another example of the kind of thing that could happen before the beginning of next year, and would certainly make us think very differently about opening the border.

Turner And if I could just back David up, I think a lot of people misunderstand that the reason that viruses mutate is lack of immunity so they can spread. The more world immunity there is, the less the virus will spread, the less mutations we will see. This virus is actually more stable than flu viruses, so we’re not expecting it ongoing for ever to constantly mutate. If we get a degree of immunity throughout the world, which will be a mixture of people being exposed to the disease and vaccination, then we are hoping to see less mutations. And that’s, you know, a key international message for all of us, and, once again, a strong message behind immunisation, that it will reduce the risk of further mutations.

Craig So thanks, Nikki.

Watts Yeah, thank you very much. Look, our New Zealand health workforce have done an absolutely terrific job to date in terms of doing what they can do to support this COVID outbreak. I guess, Professor Skegg, you know, if there was one thing from a Government policy point of view around the health workforce that we need to be working on urgently, what would you see that being? To prepare us for next year, saying that you said it’s potentially going to get a lot more bumpier than what it’s been this year.

Skegg Yes. Well, I think the most important thing is to really support the formation of the workforce. I mean, we obviously have a shortage of nurses, for example. And it’s only a few years ago—I remember because one of my daughters is a nurse—people graduating from nursing school couldn’t get jobs in the local DHB because they would prefer to get people from overseas who were more experienced. So we’ve really got to focus on training our own people. So I think, you know, it’s really important, that workforce planning and supporting health workers, because, clearly, there’s a world shortage, and we need to look after our own people.

Craig Thank you. And Nikki, did you want to have a final comment on that before we finish?

Turner No, I absolutely support it. The other thing is, you know, we are trying very hard to diversify our workforce. You’ll all be aware that last week the problems with the Delta arrival is that our one workforce is pushed between needing to swab and to vaccinate, so we’re under a lot of pressure. And thank you for the comments about supporting them. There’s a lot of people out there working really long hours at the moment. We are also working towards trying to diversify and trying to take away as many of the traditional blocks as we can, to make it as easy as possible for everyone. So we really appreciate your support on that, and we appreciate the support that, you know, the health workforce is doing its best, and we want to get out there and really support safe vaccinating rapidly as we can, while we’re swabbing loads of people.

Craig OK. Well, thank you very much. And thank you to both Professor Skegg and Dr Turner. It’s been a really informative session. And that’s us for the final session of the Health Committee for this week, so thanks for tuning in.

Skegg Thank you. Kia ora tātou.

## conclusion of evidence