

VIEWPOINT

Access to Vaccines and New Zealand’s Distinctive Response to COVID-19

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New Zealand has a well-deserved positive reputation for its handling of the COVID-19 crisis. The early closure of the country’s border in March 2020, combined with other proactive measures, allowed New Zealand to twice eliminate the virus within the community. New Zealand now has a highly vaccinated population, with 90% of the total population having received both doses of the COVID-19 vaccine, in contrast to the United Kingdom (75%) and the United States (68%).¹ New Zealand’s current death toll from COVID-19 stands at 2,212 (as of November 28, 2022), equating to 45 people per 100,000 population. This is compared to 322 in the United States, 238 in France, and 289 in the United Kingdom, and below the global average of 84 per 100,000. Further, this number is low compared to countries with comparable populations of approximately five million, such as Ireland (164) and Costa Rica (177).²

When considering equitable access to vaccines, and New Zealand’s general response to the pandemic, it is important to recognize New Zealand’s foundation document, Te Tiriti o Waitangi, which was agreed in 1840 between the Crown and Māori, the Indigenous peoples of New Zealand. Crucially, article 3 of Te Tiriti sets out a commitment to equity. In this viewpoint, we consider how New Zealand’s vaccine rollout drew, to one degree or another, from the country’s distinctive approach to human rights.

Equality, equity, and access to vaccines

In New Zealand, there is a commonly held view that “equality” requires everyone to be treated in the same way. Of course, this is deeply mistaken. In human rights law, equality places obligations on the government, and other duty bearers, to implement health initiatives that are tailor-made for disadvantaged individuals and communities. Confronted with structural disadvantage, treating everyone in the same way is inequitable and inconsistent with human rights and Te Tiriti o Waitangi. To use the language of international human rights law, “temporary” or “special” measures are needed to advance equality.³ However, because the term “equality” is misunderstood, New Zealand’s health sector uses the term “equity” instead of “equality.” This is regrettable for two reasons. One, equality is reinforced by binding national and international human rights law, whereas equity is not. Thus, equality requires accessible and effective accountability, but equity does not. Second, framing something, like equality, as a human right elevates its normative status.

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Because of this misunderstanding, equity (not equality) is an explicit key component of New Zealand's COVID-19 strategy, including equitable access to vaccines. Vaccinations against COVID-19 were available to all free of charge through mobile clinics, "pop-up" vaccination centers, pharmacies, primary health care facilities, and hospitals. The commitment to equity led to numerous initiatives, including Māori vaccination training and rural initiatives (e.g., the Southern District Health Board, working with Māori health providers to vaccinate shearing gangs in rural and remote areas across the district).⁴ The Ministry of Health set aside NZD2 million for community-based disability groups to boost the vaccine rollout, including travel support to and from vaccine centers.⁵ Further, COVID-19 health information was provided online in 30 languages, including Māori, multiple Pacific languages, and sign language.⁶

Despite the government's attempts to provide equitable access to vaccines, there have been criticisms that access to vaccines was inequitable. For example, the Waitangi Tribunal, which considers alleged breaches of Te Tiriti, found that the Cabinet's decision to reject advice from officials to adopt an age adjustment for Māori in the vaccine rollout breached the treaty principles of active protection and equity.⁷ Additionally, leaders of Pacific communities criticized the lack of engagement with their communities during the government's vaccination rollout, which was a matter of particular concern when there were high numbers of COVID-19 infections among people of Pacific descent.⁸

Despite these criticisms, the data show that the government's vaccination initiatives successfully targeted minority and at-risk populations. As of November 2022, for example, 84% of the Māori population and 90.3% of the Pacific population over the age of 12 had received both doses of the COVID-19 vaccine.⁹ This is compared with 90.7% of the New Zealand European/other population and 92.7% of the New Zealand Asian population.¹⁰ However, the number of fully vaccinated children aged 5–11 in New Zealand is relatively low (under 30%), with only 50% having had the first dose of

the vaccine.¹¹ This is lower for Māori children (under 10%) and Pacific children (20%).¹²

The courts have challenged a range of COVID-19 public health measures. However, none of the litigation to date has considered equitable access to vaccines; most have been judicial review challenges to the vaccination mandates for some workforces, such as police and teachers. These cases have addressed important human rights issues falling beyond the scope of this essay.

New Zealand's distinctive human rights and Te Tiriti response to the pandemic

As we indicate above, New Zealand's vaccine rollout did not explicitly rely on the human rights term "equality." Other features of New Zealand's response to COVID-19, which arose from human rights and Te Tiriti o Waitangi, played a positive role in the vaccination rollout. The features are interconnected, overlapping, and woven together by a conviction that human rights and Te Tiriti depend on fostering harmonious relationships within and between communities.

First, the response to COVID-19 embraced a holistic vision of human rights and not just the classic code of civil and political rights that is found in the International Covenant on Civil and Political Rights and reflected in the New Zealand Bill of Rights Act of 1990. In addition to civil and political rights, the COVID-19 response considered some workers' rights, social rights (e.g., the rights to health care and health protection), and Indigenous peoples' rights. The application of these human rights was mostly implicit, uneven, and more muted than we wished, but they were in the mix. For example, features of workers' rights, such as the critical importance of creating a safe working environment, contributed to vaccination initiatives for employees.¹³

Second, this larger vision of human rights led to a different way of framing health measures, such as vaccine mandates, passes, and mask wearing. The health measures were not always framed by the government or the Human Rights Commission as *restrictions* on human rights.¹⁴

Instead, the holistic human rights vision led to a discussion about the need to balance competing human rights—for example, striking fair and reasonable balances between the rights to life, health care, and health protection, on the one hand, and the rights to work and freedom of movement and assembly, on the other. Framed in this way, the health measures became measures that *protected* human rights (such as the rights to life, health care, and health protection) instead of measures that *restricted* human rights (such as the rights to work and freedom of movement and assembly). New data, information, and relevant circumstances were kept under constant review by the government, the Human Rights Commission, and others to ensure that the balances struck between competing rights were current, fair, and reasonable. Medical exemptions were available, for example, to employees whose workplaces fell under a vaccination mandate order but who were unable to get vaccinated for medical reasons, thereby balancing the right to health protection and the right to work.

Third, New Zealand's response to COVID-19 recognized that individuals not only have human rights (i.e., entitlements) but also have responsibilities to one another, as envisaged in the Universal Declaration of Human Rights: "everyone has duties to the community in which alone the free and full development of [their] personality is possible."¹⁵

Te Tiriti o Waitangi also recognizes that individuals have responsibilities to others in the past, present, and future. Accordingly, in the context of COVID-19, individuals' responsibilities may include the duty to get vaccinated, remain masked, maintain social distancing, and not travel between regions during lockdown. For example, checkpoints and roadblocks designed to control travel between some regions were widely accepted as appropriate for a limited period. Māori iwi (tribes) and hapū (local extended families), police, local councils, and civil defense recognized when the checkpoints should be withdrawn.

The sense of personal responsibility toward the community was often evident in the inclu-

sive and collective language used around the COVID-19 response, including the drive to get vaccinated.

Conclusion

In this viewpoint, we have highlighted equitable access to vaccines and have not sought to provide a comprehensive human rights analysis of New Zealand's response to COVID-19. That said, in our view, there is much to commend in New Zealand's response to the pandemic.

However, the fundamental values and safeguards embedded within human rights and Te Tiriti should have been at the heart of the government's response. Without always considering human rights consistently and explicitly, the government was able, for the most part, to give effect to human rights because the values that guided its COVID-19 response aligned with the values embodied in human rights instruments and Te Tiriti.

Although the government made positive references to human rights and Te Tiriti in key documents, it was sometimes unclear how these obligations were being implemented in practice. Given the complexity and rapid pace of the crisis, initiatives that did not consider human rights or Te Tiriti sometimes fell short—for example, the Ministry of Health's decision not to share Māori health data with Māori organizations.¹⁶

At the Human Rights Commission, we developed a holistic human rights and Te Tiriti approach to the pandemic response, which we constantly reviewed and adapted to the changing situation. As discussed, this approach was not always suitably adopted by the government.

In accordance with Te Tiriti, Crown-Māori relationships should be elevated from sporadic engagement to substantive partnership and equitably shared decision-making. Government efforts, such as funding support for Māori, the ramping up of targeted testing, and the Ministry of Health's Māori Response Action Plan, which included a significant focus on equity, were welcome. There was also a commitment from the

ministry to work together with its Tiriti partners. Nonetheless, neither human rights nor Te Tiriti were adequately integrated across the response to the pandemic.

Disclaimer

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References

1. Ministry of Health, "COVID-19 Data and Statistics," <https://covid19.govt.nz/news-and-data/covid-19-data-and-statistics/>; World Health Organization, "WHO Coronavirus (COVID-19) Dashboard," <https://covid19.who.int/table>.
2. World Health Organization (see note 1).
3. Convention on the Elimination of All Forms of Discrimination against Women, G.A. Res. 34/180 (1979), art. 4; Committee on the Elimination of Discrimination against Women, General Recommendation No. 25, UN Doc. A/59/38 (2004).
4. P. Henare, "Major Milestones for Māori COVID-19 Vaccine Rollout as New Campaign Launches," [Beehive.govt.nz](https://www.beehive.govt.nz/release/major-milestones-m%C4%81ori-covid-19-vaccine-rollout-new-campaign-launches) (September 19, 2021), <https://www.beehive.govt.nz/release/major-milestones-m%C4%81ori-covid-19-vaccine-rollout-new-campaign-launches>.
5. C. Hipkins and C. Sepuloni, "Dedicated Team to Support Disabled People to Access COVID-19 Vaccine," [Beehive.govt.nz](https://www.beehive.govt.nz/release/dedicated-team-support-disabled-people-access-covid-19-vaccine) (October 6, 2021), <https://www.beehive.govt.nz/release/dedicated-team-support-disabled-people-access-covid-19-vaccine>.
6. New Zealand Government, "Unite against COVID-19: Languages and Resources," <https://covid19.govt.nz/languages-and-resources/translations/>.
7. Waitangi Tribunal, *Haumarū: The COVID-19 Priority Report* (December 2021) <https://waitangitribunal.govt.nz/assets/Documents/Publications/Covid-Priority-W.pdf>.
8. "Community Leaders Say Govt's Vaccine Rollout Plan Is Not Working for Pasifika," *Radio New Zealand*, <https://www.rnz.co.nz/international/pacific-news/449914/community-leaders-say-govt-s-vaccine-rollout-plan-is-not-working-for-pasifika>.
9. Statistics New Zealand, "COVID-19 Data Portal," <https://www.stats.govt.nz/experimental/covid-19-data-portal>.
10. *Ibid.*
11. Ministry of Health, "COVID-19 Vaccination Data," <https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-vaccine-data>.

12. Statistics New Zealand (see note 9).

13. New Zealand Government, "Unite against COVID-19: Vaccination Toolkit for Businesses," https://covid19.govt.nz/assets/vaccine_toolkit_for_businesses_2021.pdf.

14. International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI) (1966), arts. 4, 12, 21; New Zealand Bill of Rights Act (1990), sec. 5.

15. Universal Declaration of Human Rights, G.A. Res. 217A (III) (1948), art. 29(1).

16. *Te Pou Matakana Limited v Attorney-General* [2021] NZHC 3319, 6 December 2021, <https://www.courtsofnz.govt.nz/assets/cases/2021/2021-NZHC-3319.pdf>.