

David Skegg

This article is an edited version of the Sir Frank Holmes Memorial Lecture delivered by Sir David Skegg at Victoria University of Wellington on 12 November 2020.

The Covid-19 Pandemic lessons for our future

It is a pleasure and a privilege to be giving this lecture. A pleasure, because I have always had affection and respect for this university, ever since I was billeted here as a student in the University of Otago debating team. And it is a privilege to be giving the Sir Frank Holmes Memorial Lecture.

Frank Holmes was the president of the Otago University Students' Association in 1947. Speaking from experience, I must admit that vice-chancellors don't always see their student presidents as destined to become notable scholars or leaders in public life. Yet the list of OUSA presidents contains many distinguished names, including that pioneer of anthropology and Māori health improvement, Sir Peter Buck (Te Rangi Hīroa). There are also

three current members of Parliament, including the deputy prime minister and a new member of the Cabinet, Ayesha Verrall.

Frank Holmes, during a long career as an economist here at Victoria, was not only a respected university leader, but also someone who helped to chart New Zealand's social and economic future. He served on an astonishing range of public advisory bodies and corporate boards. And he was

David Skegg, an epidemiologist and public health physician, is an emeritus professor at the University of Otago. He was previously the vice-chancellor of the university. As well as advising the World Health Organization for more than three decades, he has chaired many government bodies, including the Health Research Council and the Public Health Commission. He was also the president of the Royal Society Te Apārangi. In 2020 he served as a special adviser to Parliament's Epidemic Response Committee, and he was called as a witness by the equivalent select committee of the UK House of Commons.

one of the founders of the Institute of Policy Studies at this university.

Returning to the University of Otago to receive an honorary degree, 50 years after his student presidency, Sir Frank said that he had been told how one of his academic colleagues saw him:

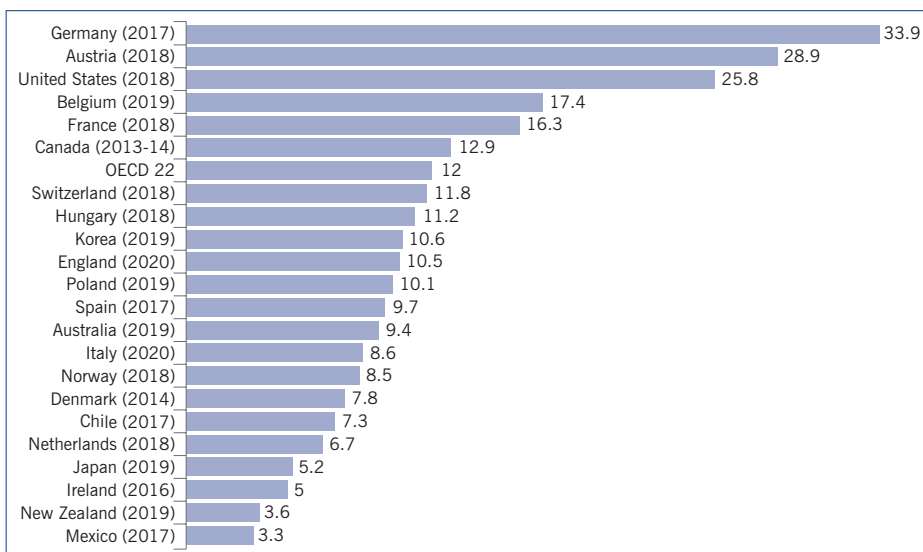
At the end of a conversation about my propensity to move in and out of the university and to take on advisory assignments for governments and others while I was employed there, he said: 'He's not really an academic, is he?'

Fortunately, universities have a broader view of their mission today.

As we face the challenge of rebuilding our future in the midst of the Covid-19 pandemic, it is a great pity that we cannot draw on the vision and wisdom of Frank Holmes. I will say a few words about likely effects of this pandemic on our national life, but I cannot pretend to be an economist or a social scientist and so will focus largely on the health of the people.

That is my first disclaimer. The second disclaimer is that everything I say must be seen as provisional. We are learning more about Covid-19 every day, and the global

Figure 1: Capacity of intensive care beds (per 100,000 population) in selected OECD countries



Source: OECD (2020)

pandemic is still rampant, so things might change here as early as tomorrow.

The emergence of Covid-19

On 6 November 2019, the prime minister unveiled a national memorial to 9,000 New Zealanders who died in the 1918 influenza pandemic. I doubt if she envisaged that a new pandemic was about to be unleashed on the world. Perhaps we should not have been surprised, as scientists had been warning for years that viral pandemics were becoming increasingly likely. Some countries had recently dealt with epidemics of infectious diseases new to humans, such as SARS and MERS. Moreover, New Zealand has been part of the ongoing HIV/AIDS pandemic, which the World Health Organization (WHO) estimates has killed about 33 million people so far.

It was in late December that reports emerged about a mysterious new disease in Wuhan, China. There has been justified condemnation of attempts by the Wuhan authorities to suppress this unwelcome news, but less acknowledgement of the remarkable progress made by Chinese doctors and scientists. A coronavirus was identified as the cause of the illness by 8 January 2020, and the genome sequence of this virus was made public only four days later. The disease spread quickly to all provinces of mainland China, but the country then mounted what has been described as ‘perhaps the most ambitious, agile and aggressive disease containment

effort in history’ (WHO, 2020, p.16). Meanwhile, Chinese doctors published, in international journals, crucial observations on the clinical features and range of outcomes of the illness.

The WHO was notified about the outbreak at an early stage, and it worked closely with the Chinese authorities. It arranged for a joint mission of experts from eight countries to spend nine days in China from 16 February. Their incisive report is a landmark document that informed control efforts in all countries, including New Zealand (WHO, 2020).

The WHO has been criticised, especially by American politicians, for being complimentary about the Chinese response to the outbreak. Yet it was a major achievement to persuade the communist authorities to host a fact-finding mission of experts from other countries, even if restrictions were placed on the scope of their enquiries. Imagine if this epidemic had started in the United States, as may well have been the case with the 1918 influenza pandemic – even though it is often mistakenly called the ‘Spanish flu’ (Crosby, 1993). How would President Trump have reacted if the WHO had proposed that a posse of scientists from other countries should come and try to get to the bottom of things?

What is remarkable is that health authorities in many Western nations were so slow to recognise the gravity of the threat, despite repeated warnings from the Chinese and from the WHO. The editor of *The Lancet*

has described this as ‘the greatest science policy failure for a generation’ (Horton, 2020, p.41). Delayed and inadequate action has led to hundreds of thousands of deaths in Europe and the United States. Sadly there will be many more, and perhaps an even greater number of people afflicted by chronic effects of infection that are still being clarified – the so-called ‘Long Covid’.

Meanwhile, a number of Asian countries were being far more successful in controlling the virus. They had learned much from the SARS epidemic in 2003, but Western countries were reluctant to follow their advice. The fact that the United States and Britain, which have led the world in medical and public health sciences, failed so miserably in responding to a known pandemic threat has been a supreme irony of this pandemic. David King, a former chief science adviser to the UK government, blamed ‘arrogance’ and ‘hubris’ (Kirkpatrick, Apuzzo and Gebre, 2020).

Early responses in New Zealand

Hubris was not an option in this country, because health professionals knew only too well that we were ill-prepared. The country has no public health commission or centre for disease control, and the Ministry of Health did not even employ epidemiologists. A Global Health Security Index, published a few months before the pandemic, ranked New Zealand as 35th in the world for pandemic preparedness (Cameron, Nuzzo and Bell, 2019).

Spending on public health services in New Zealand shrank markedly between 2010 and 2018 (Crampton, Matheson and Cotter, 2020). The public health units in our district health boards (DHBs) have been underfunded for years, so they had only a limited capacity for contact tracing. But the DHBs had a more compelling concern. They knew they lacked the surge capacity to cope with an influx of critically ill patients, as seen in countries that were only a few weeks ahead of us in the pandemic. Our hospitals have often been dangerously stretched, even by routine winter outbreaks of influenza. Among 22 OECD countries, the provision of intensive care beds (per capita) in New Zealand has been less than one-third of the average (OECD, 2020). New Zealand is in 21st place, followed only by Mexico (Figure 1).

On 5 March 2020, after New Zealand's third case of Covid-19 had been confirmed, the prime minister gave an assurance which indicated that she had been badly misinformed. She said that New Zealand's 'world-class' health system was geared up to deal with the outbreak: 'Our public health system is designed for [an outbreak] like this ... I have every faith in our system' (Walls, 2020). Only three weeks later, the government was forced to impose one of the strictest lockdowns in the world.

A change of strategy

A senior government minister, Chris Hipkins, later acknowledged that the Cabinet was still expecting New Zealand's hospitals to be 'completely overrun' by coronavirus cases when the country moved into the highest level of lockdown (Wiltshire, 2020). But this hastily adopted measure actually provided the opportunity for a change of strategy.

New Zealand, like many countries, had an influenza pandemic plan, and the prime minister received advice that led her to assure Parliament on 11 March that it was 'designed for exactly these situations' (Ardern, 2020). Yet it became more and more evident that Covid-19 is very different from seasonal influenza, and not just because it is many times more fatal. Philip Hill and James Ussher, from the University of Otago, were among those who noted that people who get infected with this coronavirus take more days before becoming infectious to others than people who develop influenza (Hill and Ussher, 2020). This explained why some Asian countries were successful in controlling Covid-19, at least partly through testing, together with rapid tracing and isolation of contacts before they could infect other people.

With influenza pandemic plans, contact tracing and isolation are abandoned once community transmission is established. In contrast, the properties of this coronavirus make elimination of Covid-19 a realistic proposition. Epidemiologists define 'elimination' as the reduction of case transmission to zero or to a predetermined very low level (Porta, 2014). A distinction is made from 'eradication', which normally means the worldwide extermination of an infection. Two professors at the Wellington campus of the University of Otago, Michael

Baker and Nick Wilson, became strong advocates for an elimination strategy.

In many countries, including the United Kingdom, the initial strategy for dealing with Covid-19 could be described as 'mitigation'. One of the aims of this approach was to achieve 'herd immunity', a state in which an infection stops spreading through a population because a sufficient proportion of people have become immune to that infection. Although many public health officials and politicians are now

to commit to it publicly. They could see that the best health response would also be best for society and for the economy. Why was the decision courageous? Because we all knew that failure was entirely possible. In so many other countries, politicians were afraid of failing and they adopted less ambitious goals. Every night, on our television screens, we can see the terrible consequences of allowing this virus to get out of control.

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denying that this was ever their aim, the historical record is clear. It was soon realised that, even if herd immunity were attainable in the absence of vaccination – which now seems highly unlikely – health services would be utterly overwhelmed and the huge number of deaths would be unacceptable. So most countries switched to a policy of 'suppression', aiming to 'flatten the epidemic curve' and protect health services from collapsing. Meanwhile, a number of Asian countries, including China, had elimination as their goal.

As Minister Hipkins acknowledged, the New Zealand government had not adopted a goal of elimination when the lockdown was imposed. At the first meeting of Parliament's Epidemic Response Committee, in the following week, the then minister of health (David Clark) gave a lengthy presentation about the government's strategy (Clark, 2020). He did not once mention elimination. Instead, he alluded to suppression, wanting to 'bend the curve', 'avoid a single large surge of cases', or 'spread the cases over several smaller waves'. On the day after that meeting, however, the government announced that it would adopt an elimination strategy.

That was a crucial decision, and I salute the prime minister and her Cabinet for having the courage to adopt that goal and

Reasons for success

I do not need to recount the ups and downs of the following weeks and months. There were delays in expanding criteria for testing, problems in scaling up contact tracing, and repeated failures in border controls. Many of us have been critical of particular matters, but the overall result has been brilliant.

As an example, let us compare New Zealand with Scotland, which also has just over five million people. New Zealand has had a total of 25 deaths during the pandemic. Scotland had 64 deaths yesterday (11 November 2020), and has had more than 4,500 deaths so far. A great many more Scots have experienced serious illness, which has become chronic in some cases. Moreover, the social and economic life of places like Scotland will continue to be stymied for many months.

What were the key factors that enabled New Zealand to achieve elimination?

- First, it must be acknowledged that we enjoyed some natural advantages, as an island nation with a relatively low population density. On the other hand, a number of other countries with similar advantages have done poorly.
- Restricting entry through our borders from an early stage limited the influx of people carrying the virus.
- Our lack of preparedness and shortage of intensive care facilities prompted an

early lockdown. Paradoxically, this turned out to be a fortunate circumstance.

- The lockdown was unusually rigorous, although also brief compared with those in a great many other countries.
- There was excellent communication – not only from political leaders and health officials fronting media conferences, but also from the civil servants responsible for communications and public engagement.
- The government listened to scientific

laboratories around the country. Finally, the commitment of the New Zealand public was fundamental.

Dorothy Porter wrote:

An epidemic is a sudden disastrous event in the same way as a hurricane, an earthquake or a flood. Such events reveal many facets of the societies with which they collide. The stress they cause tests social stability and cohesion. (Porter, 1999, p.79)

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advice about weaknesses in the response to the pandemic. Willingness to change tack in the light of experience or new evidence was essential.

- The news media played a constructive and vital role. They kept people informed about what was happening, both in New Zealand and overseas. Inquiring reporters uncovered information that was helpful to many groups, including epidemiologists.
- There was wonderful support from most people in the community, and that was enhanced by excellent political leadership.
- Finally, while it would be ridiculous to attribute all our success to good luck, we were fortunate on a number of occasions when there were new incursions of the virus into the community.

At a meeting of the Epidemic Response Committee in April, I said that if we were successful, eliminating Covid-19 would be one of New Zealand's greatest achievements (Skegg, 2020). I still believe that to be the case. We owe a debt of gratitude to politicians from more than one party, to public servants in the Ministry of Health (ably led by Ashley Bloomfield) and in several other ministries, and to hard-working staff in public health units and

I think we can feel proud that New Zealand passed this test.

While we live in a relatively caring and cohesive society, New Zealanders unfortunately have a bent towards complacency. It is almost certain that the virus will keep finding its way through our borders – we have had eight incursions detected in three months – so future outbreaks should be expected. Can such outbreaks be stamped out quickly, by testing and contact tracing, without the need for further lockdowns? I would feel more confident if people were practising sensible physical distancing, wearing masks on public transport, getting tested promptly when they have symptoms, and consistently using a contact tracing app (preferably with a Bluetooth function).

Bending the bars of our gilded cage

New Zealanders at present enjoy freedoms and security that are becoming distant memories in many countries. Our children are in school; public gatherings are unrestricted; people can enjoy sport, restaurants and internal travel; and the health system is not disrupted by an unrelenting burden of coronavirus cases. In many countries, disruptions to health care may cause even more deaths than the virus itself.

New Zealand does face substantial costs, both social and economic, as a result of the lockdowns and continuing border restrictions. Those costs fall unevenly on different people. Some of us are hardly affected, while others have lost their entire livelihood.

It is important to recognise that many of the burdens are due to the global pandemic, rather than to decisions by the government. For example, while international tourism in New Zealand was halted by our border restrictions, international passenger traffic worldwide was down by 92% in July compared with the previous year (Skapinker, 2020).

Analyses by the International Monetary Fund suggest that full economic recovery depends on keeping the virus under control (Grigoli and Sandri, 2020). In places where Covid-19 is spreading, voluntary social distancing has been found to have severe detrimental effects on a country's economy. A report from the international consultants McKinsey & Company concludes that governments with a 'near-zero-virus strategy' can achieve a much better economic outcome than countries attempting a 'balancing act' (Charumilind et al., 2020).

Nevertheless, we all want to progress towards normality as soon as possible. So how might we start to bend the bars of our gilded cage?

- As I have already mentioned, it now seems unlikely that herd immunity could be achieved without vaccination, even in countries where the pandemic is raging. In such populations, the proportion of people carrying antibodies is still far below the level that modelling indicates would be required. Moreover, there is uncertainty about how long immunity conferred by natural infection will last.
- It is possible that the virus will gradually evolve over time to become less dangerous to humans. So far there is no evidence that is occurring.
- In future there may be reliable ways of screening people who wish to travel between countries, to ensure they pose no risk of infecting others. A huge amount of work is being done to develop suitable tests, but further progress is required.

- If there were an effective and safe way of treating Covid-19, many of the current restrictions could be lifted. While there have been some advances in supporting people with severe Covid-19, such as with steroid therapy, specific antiviral agents are still needed.
- At present, vaccination offers the best hope of a route to a 'new normal'. The speed at which numerous vaccines are being developed around the world is unprecedented. Early results from clinical trials of the first candidates are encouraging. Many questions will need to be answered. How effective is a vaccine, especially in the groups (such as the elderly) who are most likely to suffer severe effects from Covid-19? How long will the immunity last? Will the vaccine merely protect an individual recipient from becoming ill, or will it prevent transmission of the virus to other people? How safe will it be, in the short and long term? And what proportion of people in each country will accept it?

I am hopeful that one or more of the vaccines approaching the final stages of evaluation will provide New Zealand with the opportunity to relax border controls and engage more freely with the rest of the world. The optimal strategy for achieving this will depend not only on properties of the vaccines, but also on the availability and uptake of vaccination in New Zealand and many other countries.

A different future

Many misfortunes – the AIDS pandemic, hijacking of planes, the destruction of the Twin Towers in New York – have led to permanent changes in the way people live. Covid-19 will be no different. It will be with us for many years, because vaccination programmes cannot be expected to achieve global eradication. Even as the threat diminishes, some things will never be the same again.

Already one can speculate about developments during 2020 that are likely to become permanent. Working from home will be more common than in the past. This should limit the growth of city traffic and save office accommodation, but there will be a loss of collegiality – not least in universities. Air travel for work will

diminish, as more meetings are held by Zoom or similar means. At least these developments will be beneficial in regard to climate change. It is also expected that more work will be automated, with displacement of many jobs.

I hope that our leaders will now be more focused on building the resilience of our society and economy. The Covid-19 pandemic should have brought home to people that we are interdependent; our safety relied on everyone pulling together. People in occupations that have not been accorded high status, such as carers or

also been reminded how important it is to maintain some manufacturing capacity within the country, when supply lines can be disrupted by an international emergency.

The threat of further pandemics

Some people talk about Covid-19 as a 'once in 100 years event'. That is highly improbable. In recent decades, emerging infectious diseases have been reported with increasing frequency, with many originating from an animal source (Jones et al., 2008). Advances in biotechnology have also raised the possibility that novel

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supermarket assistants and delivery drivers, played an essential role. Society will be more resilient if there is less inequality and a fairer distribution of wealth.

Epidemics usually have a disproportionate effect on groups in society that are already disadvantaged. In New Zealand, Māori and Pasifika people are particularly vulnerable. While our success in controlling Covid-19 has prevented the carnage seen in other countries, job losses and other economic shocks will affect some groups more than others.

The pandemic has exposed the lack of resilience of our economy. Excessive dependence on mass tourism and international students made us particularly vulnerable to restrictions on international travel. It seems unlikely that cheap international travel will return to its previous frenetic state in the foreseeable future. Covid-19 has been a more potent force than the environmental movement for *flygskam*, or flight shame. Diversifying an economy is easier said than done, but I hope there will now be radical thinking about how this can be achieved. We have

agents may be created in the laboratory and released as biological weapons. The scale and speed of international travel have made it more likely that new infectious agents will spread rapidly around the globe. A new pandemic could occur within the next year or two, and it might carry a much higher risk of death than Covid-19. It has been suggested that the whole future of our species, or at least our civilisation, could be put at risk.

The threat of new pandemics underlines the importance of global cooperation in detecting and controlling emerging diseases. The role of international agencies, including a strengthened WHO, has never been more crucial. The last thing we need is the chauvinistic nationalism that has been evident in some quarters. In addition, New Zealand, like every other country, needs to make its own preparations, so that we can respond quickly and effectively.

I hope there will be a full public inquiry, in due course, to examine New Zealand's response to the Covid-19 pandemic. That will expose our lack of preparedness, in regard to both clinical facilities (such as intensive care

beds) and public health capability. A resilient health system requires the capacity to cope with surges in demand. Unfortunately, both National- and Labour-led governments have been failing to invest adequately in health services as the population grows and ages, and as advances in medical technology make modern care more expensive.

The prime minister herself, during the lockdown, remarked that politicians had not been aware of the importance of

Here in New Zealand, we are especially affected by what can be described as an obesity pandemic (Swinburn et al., 2011; Skegg, 2019). More than one-third of New Zealand children and two-thirds of adults are now either overweight or obese. Obesity has already overtaken smoking as a cause of health loss in this country. The problem disproportionately affects Māori and Pasifika people, as well as those living in deprived areas. According to a report

but I hope those relating to public health will be reconsidered in the light of our experiences this year.

The chapter on 'Population health' calls for 'a determined and ambitious shift towards prevention and promotion of health and wellbeing with strengthened national capacity and capability'. The report contends that this 'cannot be achieved by carving population health off to the side'. These are fine words, but I have concerns about some of the mechanisms proposed.

The report recommends that the Ministry of Health should have a strengthened leadership role, while the existing Health Promotion Agency would be disbanded. The crucial function of monitoring and analysing the state of the public health (often called 'public health intelligence') would be spread across several organisations: the ministry, a new body to be called Health NZ, and a new Māori Health Authority. The funding for population health work in the regions would be devolved to the DHBs, rather than being subject to separate contracts with ring-fenced funding, as at present. There is little emphasis in the report on the important functions of public health policy and advocacy, but the panel recommends that a Public Health Advisory Committee should be re-established.

Several of these recommendations closely resemble approaches that have been tried in the past, without success. For example, the devolution of funding for public health to DHBs recalls the arrangements (and the rhetoric) for area health boards in the late 1980s. Most of those area health boards manifestly failed public health, with resources being siphoned off into treatment services (National Interim Provider Board, 1992). That was one of several reasons why a Public Health Commission was established (Skegg, 2019).

There are a range of matters that need to be considered in designing a more effective system for public health in New Zealand (Crampton, Matheson and Cotter, 2020). Here I want to focus on just one aspect: the need for independent and authoritative advice to the government and to the community about public health challenges. While the Ministry of Health is

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public health, and of the work done every day by public health professionals in DHBs and other agencies. Public health can be defined as 'the science and art of preventing disease, prolonging life and promoting health through organised efforts of society' (Committee of Inquiry, 1988, p.1). People will be shocked if a New Zealand inquiry reveals the critical shortage of public health expertise in the Ministry of Health. The Covid-19 pandemic has highlighted the vulnerability of our public health function – something already made obvious by recent outbreaks of *Campylobacter* infection and measles, which were a disgrace for a developed nation.

Rebuilding our public health capacity

Infectious diseases are far from being the only challenges we face. Indeed, there are other pandemics that will claim more lives. For example, we are still in the grip of a tobacco disease pandemic. The WHO estimates that tobacco kills more than eight million people every year, with about 1.2 million of those deaths being in non-smokers exposed to second-hand smoke.

on children living in 41 OECD and European Union countries, the proportion of New Zealand children and adolescents who are overweight or obese is higher than in all the other countries except the United States (UNICEF Innocenti, 2020). Our failure to protect young people from this problem means that far too many of them will grow up to suffer chronic diseases, such as type 2 diabetes and heart disease. Obesity can also lead to social rejection and victimisation, which adversely affect mental health and quality of life.

As the preventive side of health care, public health needs to confront the whole range of threats to our health and wellbeing. In a book published last year, I tried to dissect reasons for the weakness of our public health function, and to recommend possible solutions (Skegg, 2019). In June 2020, the government released a review of our health system, from an appointed panel chaired by Heather Simpson (Health and Disability System Review, 2020). Their report was largely completed before the coronavirus pandemic hit New Zealand. There are many sensible recommendations,

the key agency, it is politically accountable and cannot speak publicly and frankly on politically sensitive matters. Throughout my career I have learned that most issues in public health have the potential to become politically sensitive, often without warning. Elsewhere I have argued that the ministry needs to be complemented by a separate agency, such as a Crown entity or an officer of Parliament akin to the parliamentary commissioner for the environment (Skegg, 2019, pp.99–119). The call from the Health and Disability System Review for reinstatement of a Public Health Advisory Committee is to ‘provide independent advice to the Minister and a public voice on important population health issues’.

Public Health Advisory Committee

It may be salutary to consider previous experience with such a committee, which existed under statute from 2000 to 2016. The New Zealand Public Health and Disability Act 2000 required the National Health Committee to establish a Public Health Advisory Committee. This was to provide independent advice to the minister, as well as to the National Health Committee, on public health issues, including factors underlying the health of people and communities, the promotion of public health and the monitoring of public health. The advice given by the Public Health Advisory Committee was to be formulated after consultation with organisations and individuals, and it had to be made publicly available by the minister.

Despite sterling efforts by individuals, this committee was never able to make much impact. Like the National Health Committee, it was serviced by the Ministry of Health and tended to work on projects that were chosen by the government. In 2013, after the committee had not even met for at least a couple of years, the MP Kevin Hague alleged that it had been ‘unlawfully disbanded’. The minister of health, Tony Ryall, denied this, but conceded that it ‘had not been very active’ (Skegg, 2019, p.92).

Since recounting that episode in my book, I decided to find out what happened next. There was uncertainty about the membership of the committee, and the minister himself was unable to name the

Table 1: Duration of meetings of the Public Health Advisory Committee, 2014–16

Date of Meeting	Duration
25 March 2014	19 minutes
30 September 2014	2 minutes
16 December 2014	7 minutes
4 March 2015	6 minutes
31 March 2015	5 minutes
6 May 2015	5 minutes
28 July 2015	10 minutes
3 November 2015	2 minutes
8 December 2015	5 minutes
2 February 2016	30 minutes
4 March 2016	10 minutes

members within the time frame set for responding to a written parliamentary question. In the following year, the annual report of the National Health Committee included a cryptic statement, that ‘three of the Committee’s membership constitute the Public Health Advisory Committee’. These members were not identified, but were in fact a surgeon, a businesswoman and a retired lawyer from Wanaka.

I wrote to the Ministry of Health and asked for details of the activities of this committee between 2008 and 2016. The ministry refused to provide even the dates of any meetings between 2008 and 2013, on the grounds that the volume of collation required was ‘such that the Ministry’s ability to carry out its day-to-day work would be impaired’. Presumably this was the period when the minister had said that the committee ‘had not been very active’.

The ministry was able to provide the dates of 17 meetings between March 2014 and March 2016. Agenda papers were found for a further two meetings in 2014, but it was ‘unconfirmed if these meetings were held’, and no minutes could be found. In fact the minutes of six of the other 17 meetings of this statutory committee could not be provided, as ‘the information requested does not exist, or despite reasonable efforts to locate it, cannot be found’. This surely calls into question the adequacy of record-keeping in our public service.

Even more surprising was the duration of the meetings of the Public Health Advisory Committee. The first meeting in 2014 lasted 19 minutes, but the subsequent

meetings had a median length of five or six minutes (Table 1).

These meetings were held at hotels in Wellington or Auckland, at the Royal Auckland Golf Club, or at Eden Park. Given that some of them lasted only two minutes, it is hardly surprising that their business was largely confined to administrative matters, such as an interests register, risk register, gifts register, attendance register, hospitality register, and the minutes of the previous meeting. At the majority of meetings, however, the committee was asked to note formally that ‘the executive’ (i.e. the Ministry of Health) had not identified any matters that required the consideration of the Public Health Advisory Committee.

During years when New Zealand was facing major public health challenges, the government and the community received no relevant advice from this committee. I find it chilling that the Ministry of Health carefully engineered what can only be described as a charade, designed to subvert the purpose of an Act of Parliament.

In view of this experience, I hope it will be understood why I am sceptical about the recommendation from the Health and Disability System Review. I was pleased to see that the Labour Party manifesto, released in September, provides for the establishment of a Public Health Agency. The objectives and arrangements for this body are yet to be clarified. It should be at arm’s length from the government of the day, and equipped to provide independent advice on how best to monitor, improve and protect the health of New Zealanders.

Conclusion

As individuals we know that health is a precious commodity, and we cannot fulfil all of our potential without it. The Covid-19 pandemic has taught many nations a painful lesson, that the same is true of society. In dealing with this virus, our government was one of the first to acknowledge that the best health response

would also be the best economic response. That can also be true in the absence of a pandemic virus. Improving the health of the people is one of the keys to a successful society.

Almost 150 years ago, the Royal Sanitary Commission (1871) in Britain reached a similar conclusion:

The constant relation between the health and vigour of the people and the welfare and commercial prosperity of the State requires no argument. Franklin's aphorism, 'public health is public wealth', is undeniable (cited in Committee of Inquiry, 1988, p.i).

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