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ARTICLE

The Right to Health and COVID-19: Lessons Learned for the New Health System

ANITA YIU-HAN CHUNG*

New Zealand's health system is widely characterised as a system of inequities. Vulnerable populations such as Māori and Pasifika continue to fall behind in health outcomes, including life expectancy and disease incidence. COVID-19 exists against this background of inequity, exacerbating it in some circumstances. This article uses a right to health framework to evaluate New Zealand's COVID-19 policies. The right to health, as stated in art 12 of the International Covenant of Economic, Social and Cultural Rights (ICESCR), is the right to the "highest attainable standard of health". The core obligations of the right to health are access to healthcare, minimum essential food and housing; the provision of essential medicines; and the implementation of a national public health strategy. This article uses Audrey Chapman's interpretation of the content of the core obligations (the respect, fulfil and protect criteria) as a basis for its evaluation framework. This article finds that, while the government improved its care for vulnerable populations during COVID-19 in line with the right to health, existing inequities prevented it from fully meeting its obligations. These inequities also led to a high level of expenditure during the pandemic. Focusing on the right to health can ensure a stronger baseline for health outcomes before public health crises emerge, and can also help lessen their burden on resources when they do arise. New Zealand should create a human rights-based health system by implementing a right to health mandate in future health and disability legislation and developing key indicators for a right to health strategy.

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I Introduction

New Zealand's health system is widely characterised as a system of inequities. While it works well for some, vulnerable populations continue to fall behind in health outcomes, including life expectancy and disease incidence.[1] Vulnerable populations include Māori and Pasifika,[2] who make up 17.4 per cent and 8.1 per cent of the total population respectively.[3] These communities face intersecting barriers as Māori and Pasifika are also overrepresented in lower socioeconomic areas.[4] Our health system and other social structures have an obligation to prevent these poor health outcomes.

On 28 February 2020, New Zealand recorded its first case of COVID-19. Compared to other countries, the pandemic first broke into New Zealand with a relatively low number of cases per capita, and an accordingly low number of deaths. The international community initially described the government's COVID-19 strategy as a gold-standard response.[5] Prior to the August 2021 Delta variant outbreak, New Zealand ranked third in the Bloomberg Resilience Scale, which measured responses in terms of containing the virus with the least amount of social and economic disruption.[6]

However, as the virus exists against a background of health inequity, the impact on vulnerable and marginalised communities must be considered. During previous pandemics, such as influenza and swine flu, Māori and Pasifika rates of hospitalisation and death were higher than rates for non-Māori and non-Pasifika.[7] The COVID-19 pandemic is likely to replicate this trend, with Māori and Pasifika at higher risk of hospitalisation.[8] Further, the economic impacts of COVID-19 pose intersecting risks for Māori and Pasifika, who are overrepresented in lower socioeconomic groups. For these reasons, policy-makers should continue to evaluate and improve their protections for vulnerable populations in future pandemics and public health crises.

A right to health framework provides a useful tool to evaluate health policy initiatives. The right to health is the right to the "highest attainable standard of health".[9] While there are several instruments which refer to this right, this paper focuses on art 12 of the

1 Felicity Goodyear-Smith and Toni Ashton "New Zealand health system: universalism struggles with persisting inequities" (2019) 394 Lancet 432 at 438.

2 This article uses the term Pasifika. However, it is acknowledged that there are over 40 Pacific groups in New Zealand.

3 Stats NZ "Māori population estimates: At 30 June 2022" (17 November 2022) <www.stats.govt.nz>; and Stats NZ "Pacific Peoples ethnic group" <www.stats.govt.nz>.

4 Manatū Hauora Ministry of Health "Neighbourhood deprivation" (2 August 2018) <www.health.govt.nz>. Please note subsequent references to the Ministry of Health will be as Manatū Hauora.

5 "Covid 19 coronavirus: World Health Organisation praises New Zealand's response" *The New Zealand Herald* (online ed, Auckland, 8 September 2020).

6 Rachel Chang and others "The Covid Resilience Ranking: The Best and Worst Places to Be as Delta Wrecks Reopening Plans" (26 August 2021) Bloomberg <www.bloomberg.com>.

7 Ayesha Verrall and others "Hospitalizations for Pandemic (H1N1) 2009 among Maori and Pacific Islanders, New Zealand" (2010) 16 Emerging Infectious Diseases 100 at 101; and Nick Wilson and others "Differential Mortality Rates by Ethnicity in 3 Influenza Pandemics Over a Century, New Zealand" (2012) 18 Emerging Infectious Diseases 71 at 73.

8 Nicholas Steyn and others "Māori and Pacific people in New Zealand have a higher risk of hospitalisation for COVID-19" (2021) 134(1538) NZMJ 28 at 34.

9 Constitution of the World Health Organization (signed 22 July 1946, entered into force 7 April 1948), preamble.

International Covenant on Economic, Social and Cultural Rights (ICESCR).[10] Various levels of obligation exist within this right. This article focuses on the core obligations which, in contrast to the right to health in general, require immediate implementation. The United Nations Committee on Economic, Social and Cultural Rights' (the Committee) General Comment 14 sets out these core obligations.[11]

The COVID-19 pandemic coincided with a major health reform in New Zealand and offers valuable lessons to guide future reform initiatives. Following a full health and disability system review published in 2020, the government pledged to overhaul the health system.[12] On 1 July 2022, two new entities were formed, Health New Zealand (Te Whatu Ora) and the Māori Health Authority (Te Aka Whai Ora).[13] A new public health unit within the Ministry of Health (Manatū Hauora) was also formed.[14] These entities will prove vital in future pandemic planning and must be supported in their preparatory work for public health crises.

Drawing this together, this article aims to answer the question of whether New Zealand's COVID-19 policies were consistent with the right to health of vulnerable groups and lessons that can be learned for the reformed health system. This article argues that while the government improved its care for vulnerable populations during COVID-19 in line with the right to health, existing inequities prevented it from meeting its obligations. Ensuring a strong baseline of outcomes for future public health crises requires the introduction and use of the right to health in the reformed health system.

Part I of this article provides an overview of New Zealand health outcomes to demonstrate the background of inequity that existed prior to the COVID-19 pandemic. Part II explains the right to health under the ICESCR and its key aspects, namely the core obligations and non-discrimination. Part II also outlines how the right is currently applied in New Zealand. Part III discusses the content of the core obligations and canvases the different arguments in human rights scholarship regarding how states could meet these standards. Next, Part IV evaluates New Zealand's COVID-19 policies against the core obligations. Part IV concludes that while New Zealand implemented a range of policies that targeted vulnerable groups, these policies did not sufficiently overcome pre-existing inequities. Finally, Part V provides guidance on how the lessons from New Zealand's COVID-19 experience and the right to health can inform the development and operation of the new health system. To that end, this article proposes:

- strengthening the right to health in health and disability legislation; and
- developing specific indicators for a right to health strategy to measure New Zealand's progress in achieving the core obligations.

10 International Covenant on Economic, Social and Cultural Rights 933 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976), art 12 [ICESCR].

11 *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No 14 (2000) – The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* UN Doc E/C12/2000/4 (11 August 2000) [*General Comment 14*].

12 Health and Disability System Review Panel *Health and Disability System Review: Final Report Pūrongo Whakamutunga* (March 2020).

13 Pae Ora (Healthy Futures) Act 2022, ss 11 and 17.

14 Health Act 1956, s 3E.

II Overview of New Zealand Health Outcomes

New Zealand's health system operates on a near universally funded basis through publicly funded hospital care and partially funded primary care.[15] However, inequities continue to persist despite the universal nature of the system.[16] The COVID-19 pandemic has exacerbated existing inequities to create new challenges that must be addressed through health policy and spending.

Inequities in health outcomes are greatest amongst vulnerable groups. Specifically, Māori and Pasifika continue to face lower levels of health and life expectancy. For example, New Zealand "European or other" females have a higher life expectancy at birth (84.5 years) compared to Māori (77.1 years) and Pasifika (79 years) females.[17]

The causes of these health inequities are wide-ranging and include social factors such as economic deprivation. Māori and Pasifika are overrepresented in the most deprived areas in New Zealand.[18] However, inequities exist even within income groups, pointing towards structural determinants of health. For Māori, a key structural determinant is the lasting impact of colonisation and institutional racism.[19] Similarly for Pasifika, historical events such as the Dawn Raids have perpetuated vast forms of discrimination, negatively impacting health outcomes.[20]

Similar to trends seen internationally, COVID-19 poses more of a risk to vulnerable groups in New Zealand due to these inequities.[21] Māori and Pasifika have higher rates of conditions that make them more susceptible to serious negative effects of COVID-19, including diabetes, cardiovascular disease and chronic lung diseases.[22] COVID-19 also presents inequitable risks to Māori and Pasifika beyond underlying health conditions. A study that aimed to predict the effects of COVID-19 on hospitalisation found that an 80-year-old European/other patient with no comorbidities had the same level of predicted hospitalisation risk as a 59.3-year-old Māori patient and a 54.7-year-old Pasifika patient with no comorbidities.[23]

Social and environmental factors, including household overcrowding and social deprivation, can also increase risk of hospitalisation for COVID-19 in Māori and Pasifika communities. Māori and Pasifika populations are overrepresented in overcrowded households, with one in five Māori and two in five Pasifika living in crowded homes,

15 Goodyear-Smith and Ashton, above n 1, at 432.

16 At 440.

17 Stats NZ "National and subnational period life tables: 2017–2019" (20 April 2021) <www.stats.govt.nz>.

18 Manatū Hauora, above n 4.

19 Papaarangi Reid and Bridget Robson "Understanding Health Inequities" in Bridget Robson and Ricci Harris (eds) *Hauora: Māori Standards of Health IV: A study of the years 2000–2005* (Te Rōpū Rangahau Hauora a Eru Pōmare, Wellington, 2007) 3 at 4–6.

20 Sarah A Kapeli, Sam Manuela and Chris G Sibley "Perceived discrimination is associated with poorer health and well-being outcomes among Pacific peoples in New Zealand" (2020) 30 J Community Appl Soc Psychol 132 at 135.

21 Kamlesh Khunti and others "Is ethnicity linked to incidence or outcomes of covid-19?" (2020) 369 BMJ 1548; and Andrew Resnick, Sandro Galea and Karthik Sivashanker "Covid-19: The painful price of ignoring health inequities" (18 March 2020) The BMJ Opinion <https://blogs.bmj.com>.

22 Centers for Disease Control and Prevention "People with Certain Medical Conditions" (10 February 2023) <www.cdc.gov>; and Manatū Hauora "COVID-19: Higher risk people" (Date Accessed: 14 June 2022) <www.health.govt.nz>. Please note that Manatū Hauora has since moved this webpage to the "Unite against COVID-19" website.

23 Steyn and others, above n 8, at 37.

compared to one in twenty-five New Zealand Europeans.[24] The estimated contribution of exposure to household crowding on hospitalisation rates for selected infectious diseases (including influenza, tuberculosis and meningococcal disease) is higher for Māori (16.8 per cent) and Pasifika (24.7 per cent) compared to European/other (5 per cent).[25] Social deprivation is also a factor, with the risk of hospital admission for infectious diseases increasing in the most economically deprived populations.[26] COVID-19's highly infectious nature therefore poses an increased risk to these communities.

Evidence suggests that Māori and Pasifika are more likely to contract COVID-19 and experience severe side effects than non-Māori and non-Pasifika. In the August 2021 Delta outbreak, 40 per cent of cases were Māori and 30 per cent of cases were Pasifika.[27] Māori and Pasifika also made up 30 per cent and 40 per cent of hospitalised cases respectively.[28] Previous pandemics, such as the 2009 swine flu pandemic, also reveal a trend of increased Māori and Pasifika hospitalisations and mortality rates.[29]

These statistics paint a dire picture for Māori and Pasifika in the COVID-19 pandemic. As a result, policy-makers needed to implement policies that directly addressed the risks of COVID-19 to these groups. A right to health framework can be used to evaluate whether existing COVID-19 policies are fit for this purpose.

III The Right to Health

In 1946, the Constitution of the World Health Organisation introduced the right to health. The preamble states that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[30] In 1966, the right was recognised in the ICESCR.[31]

The Committee has discussed the relevance of the right to health to COVID-19. In a statement on COVID-19, the Committee emphasised the negative impacts that the pandemic has had on economic, social and cultural rights, particularly the right to health of vulnerable groups.[32] They pointed out that disadvantaged and marginalised groups were severely affected by the crisis and those living in poverty would bear the disproportionate burden of the economic consequences of containment measures.[33] The

24 Alan Johnson, Philippa Howden-Chapman and Shamubeel Eaqub *A Stocktake of New Zealand's Housing* (February 2018) at 44.

25 Michael G Baker and others *Infectious Diseases Attributable to Household Crowding in New Zealand: A Systematic Review and Burden of Disease Estimate* (He Kainga Oranga – Housing and Health Research Programme, 2013) at 57.

26 Michael G Baker and others "Increasing incidence of serious infectious diseases and inequalities in New Zealand: a national epidemiological study" (2012) 379 Lancet 1112 at 1116.

27 Manatū Hauora "COVID-19: Case demographics" (Date Accessed: 14 November 2021) <www.health.govt.nz>. This article relies on data available as at the date accessed and therefore may be inconsistent with present statistics currently published on the website of Manatū Hauora, which is updated weekly.

28 Manatū Hauora, above n 27.

29 See Verrall and others, above n 7, at 101; and Wilson and others, above n 7, at 73.

30 Constitution of the World Health Organization, preamble.

31 ICESCR, art 12.

32 *Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights* UN Doc E/C12/2020/1 (17 April 2020) at [2].

33 At [5]–[6].

Committee called for state parties to prioritise the core obligations under the ICESCR.[34] Further, they outlined that states must make every effort to mobilise resources to combat COVID-19 in the most equitable manner, making vulnerable groups a priority.[35]

A *ICESCR*

Within the ICESCR, art 12 sets out the right to health. Article 12(1) recognises that everyone has the right "to the enjoyment of the highest attainable standard of physical and mental health". Article 12(2) then outlines the steps that state parties must take to fully realise the right.

The Committee's General Comment 14 contains an authoritative statement about the content of the right to health.[36] This comment explains that the right to health is not the right to be healthy but rather the right to the enjoyment of facilities, goods, services and conditions necessary to achieve the highest attainable standard of health. This includes freedom of control over one's health and entitlement to a "system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health".[37] General Comment 14 further outlines the elements of the right to health are availability, accessibility, acceptability and quality.[38]

General Comment 14 also discusses the obligations imposed by the right to health. These include obligations to respect, protect and fulfil.[39] The Committee confirms that state parties have a "core obligation to ensure the satisfaction of … minimum essential levels of each of the rights enunciated in the Covenant".[40] These obligations will form the framework for this article and are discussed in detail in subsequent Parts.

(1) Progressive realisation

Article 12 must be read alongside art 2(1). Article 2(1) sets out obligations regarding all rights contained in the ICESCR. It requires:

> [e]ach State Party … to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means …

Article 2(1) indicates that the right to health is an aspirational goal which should be achieved in a progressive way. However, the progressive nature of the goal has drawn criticism from human rights scholars as it allows state parties to circumvent obligations.[41] As a result, despite goals of progressive achievement set out in art 2, the Committee and the United Nations High Commissioner of Human Rights have recognised that some

34 At [12].
35 At [14].
36 *General Comment 14*, above n 11.
37 At [8].
38 See [12] for a more in-depth explanation of each of these elements.
39 At [33].
40 At [43].
41 Lisa Forman and others "Conceptualising minimum core obligations under the right to health: How should we define and implement the 'morality of the depths'" (2016) 20 IJHR 531 at 531–532.

obligations under the right to health are to be undertaken immediately.[42] This includes the core obligations and the obligation of non-discrimination.[43]

(2) Core obligations

In 1990, the Committee introduced the minimum core obligations into international jurisprudence through General Comment 3.[44] The Committee stated that a "minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party".[45] This comment also allowed state parties to justify not meeting these obligations due to a lack of resources, provided they were able to show that all available resources were utilised toward fulfilment of these minimum obligations.[46]

The later General Comment 14 confirmed the core minimum obligations of the right to health and obligations of comparable priority. The core obligations of the right to health as stated in General Comment 14 are:[47]

> (a) [t]o ensure right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
> (b) [t]o ensure access to minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
> (c) [t]o ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
> (d) [t]o provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
> (e) [t]o ensure equitable distribution of all health facilities, goods and services; and
> (f) [t]o adopt and implement a national public health strategy and plan of action … [which] shall give particular attention to marginalized or vulnerable groups.

Contrasting with General Comment 3, the Committee stated in General Comment 14 that "a State party cannot … justify its non-compliance with the core obligations", indicating that states are unable to use resource constraints as a justification for not meeting the core obligations.[48] General Comment 14 inarguably strengthens the core obligations. However, this existence of a resource constraint justification remains an unresolved point of contention within human rights literature. While this article will not discuss the extent of New Zealand's resource constraints, it will proceed on the basis that such constraints remain a relevant consideration when evaluating the content of the core obligations in line with General Comment 3.[49]

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42 *Report of the United Nations High Commissioner for Human Rights* UN Doc E/2007/82 (25 June 2007) at [20]; and *CESCR General Comment No 3: The Nature of State Parties' Obligations (Art 2, Para 1, of the Covenant)* UN Doc E/1991/23 (14 December 1990) [*General Comment 3*] at [1].

43 Office of the United Nations High Commissioner for Human Rights *Fact Sheet No 33: Frequently Asked Questions on Economic, Social and Cultural Rights* (2008) at 15–16.

44 *General Comment 3*, above n 42, at [10].

45 At [10].

46 At [10].

47 *General Comment 14*, above n 11, at [43].

48 At [47].

49 Reasons for this will be discussed in Part III.

(3) Non-discrimination

While included within the core obligations, non-discrimination cuts across all rights in the ICESCR. Article 2(2) sets out an obligation for state parties to "guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind". The Committee described discrimination as:[50]

> … any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise … of Covenant rights.

Article 2(2) requires formal and substantive elimination of discrimination. The Committee suggested that states adopt measures to suppress conditions that perpetuate discrimination.[51] These measures may include legislation, policies, accountability mechanisms and ways of monitoring progress.[52]

B *How is the right to health applied in New Zealand?*

New Zealand ratified the ICESCR on 28 December 1978.[53] Since then, successive governments have taken steps to progressively achieve its obligations under the ICESCR. In terms of the right to health, this includes health policies and interventions which are reported to the Committee. However, there are also elements missing from the achievement of these rights—such as the lack of specific legislation implementing the ICESCR into domestic law.

(1) Accountability and reporting

Articles 16 and 17 of the ICESCR requires that all states submit periodic reports in respect of the Covenant. New Zealand's latest report details how New Zealand is progressively achieving all rights under the ICESCR.[54] In response to this report, the Committee recommended that New Zealand "intensify its efforts to close the gaps in the enjoyment of the right to health by improving the health outcomes of Māori and Pasifika, in close collaboration with the groups concerned".[55] The Committee also drew New Zealand's attention "to its general comment No. 14 (2000) on the right to the highest attainable standard of health".[56] In line with these recommendations, this article identifies ways that New Zealand could improve the right to health of Māori and Pasifika communities by analysing policies through the lens of the core obligations found in General Comment 14.

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50 *General Comment No 20: Non-discrimination in economic, social and cultural rights (art 2, para 2, of the International Covenant on Economic, Social and Cultural Rights)* UN Doc E/C12/GC/20 (2 July 2009) at [7] (footnote omitted).

51 At [8]–[9].

52 At [37]–[41].

53 Ministry of Justice "Constitutional issues & human rights: International Covenant on Economic, Social and Cultural Rights" (19 August 2020) <www.justice.govt.nz>.

54 *Fourth periodic report submitted by New Zealand under articles 16 and 17 of the Covenant, due in 2017* UN Doc E/C12/NZL/4 (6 October 2017) [*Fourth periodic report*].

55 *Concluding observations on the fourth periodic report of New Zealand* UN Doc E/C12/NZL/CO/4 (1 May 2018) [*Concluding observations*] at [45].

56 At [45].

This article's evaluation differs from the standard reporting required by the Committee as it focuses on COVID-19 policies.

(2) Legislation

New Zealand's latest report to the ICESCR discussed how an international treaty is only directly enforceable in New Zealand if it is implemented into domestic law. The report pointed out that while there is no explicit recognition of the right to health in the New Zealand Bill of Rights Act 1990 (NZBORA), "[t]here is a general presumption that, in the absence of clear contrary intention, legislation (i.e. statutory powers) should be interpreted consistently with New Zealand's international obligations."[57] Analysing existing health and disability legislation reveals that various statutes inadvertently incorporate aspects of the right to health, but do not state it as it is set out in the ICESCR.[58]

The Health and Disability Services (Safety) Act 2001 promotes the safe provision of health and disability services by establishing standards and encouraging providers to take responsibility for safe delivery of services.[59] The Act also aims to encourage providers to continuously improve the quality of services. Similarly, the Health Practitioners Competence Assurance Act 2003 aims to protect public health and safety through ensuring practitioners are competent and fit for practice.[60] These Acts reflect the quality component of the right to health.

The Pae Ora (Healthy Futures) Act 2022 establishes new health entities as part of the health system reform implemented on 1 July 2022.[61] The right to health is not explicitly included in this Act, although elements of the right can be found in the health sector principles which guide the Act.[62] This includes ensuring equity through access to services in proportion to health needs and the provision of services that are culturally safe and culturally responsive.[63] A key purpose of the Act is to provide for services in order to "achieve equity in health outcomes among New Zealand's population groups".[64] These provisions of the Act reflect the accessibility, acceptability and non-discrimination elements of the right.

Aspects of the right to health also align with the Crown's obligations under Te Tiriti o Waitangi. For example, art 1 of Te Tiriti protects tino rangatiratanga, which includes rights of self-determination, although it is not limited solely to this meaning.[65] Manatū Hauora interprets tino rangatiratanga as "[providing] for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services".[66] Other

57 *Fourth periodic report*, above n 54, at [12].
58 Human Rights Commission *Human Rights in New Zealand: Ngā Tika Tangata O Aotearoa* (2010) at 156.
59 Health and Disability Services (Safety) Act 2001, s 3.
60 Health Practitioners Competence Assurance Act 2003, s 3.
61 Further discussion about this reform is contained in Part V.
62 Pae Ora (Healthy Futures) Act, s 7.
63 Sections 7(1)(a)(i) and 7(1)(d)(ii).
64 Section 3(b).
65 Valmaine Toki "Māori Seeking Self-Determination or Tino Rangatiratanga? A Note" (2017) 5 Te Tai Haruru Journal of Māori and Indigenous Issues 134 at 143. Toki notes that self-determination is an international law norm but tino rangatiratanga exists independently of these norms.
66 Manatū Hauora *He Mana tō Te Tiriti o Waitangi* (August 2020) at 2.

principles of Te Tiriti include active protection and equity.[67] These principles require the Crown to achieve equitable health outcomes for Māori, which is also required by the right to health.

Although New Zealand has not explicitly incorporated the right to health or the core obligations into its domestic legislation, this statutory analysis shows that aspects of the right are inadvertently included in New Zealand's health laws. This raises questions as to whether there should be full recognition of the right in law, similar to other jurisdictions.[68] However, inadvertent incorporation of the right into statute also provides support for using the right to health to evaluate New Zealand's policies, as it shows that the right remains an important part of the New Zealand health landscape. The core obligations are a useful tool for this evaluation.

IV The Core Obligations as a Framework

Whether New Zealand's COVID-19 response satisfied its obligations under the right to health requires evaluation using a rights-based framework. The core obligations are used as a basis for this framework because states must implement these obligations immediately rather than progressively. This requirement of immediate implementation means that during COVID-19, New Zealand was required to have policies in place that aligned with the core obligations. The United Kingdom has also used these core obligations to assess COVID-19 policies.[69]

This article uses the core obligations from General Comment 14 as the starting point for an evaluation framework. They have been further modified to reflect the New Zealand context. While there were originally six core obligations listed in General Comment 14, this article combines the obligations of non-discriminatory access to healthcare and the equitable distribution of healthcare because the distribution of healthcare often informs access. Access to minimum essential food will be assessed separately from access to shelter and housing, as food poverty and housing are both significant issues in New Zealand. Access to portable water and sanitation will not be assessed on their own, and instead access to shelter and housing will serve as a proxy. Discussion of the obligation to provide essential drugs will focus on immunisation, as this is also an obligation of comparable priority in the context of COVID-19. Following these changes, the core principles are:

- non-discriminatory access and equitable distribution of healthcare;
- access to minimum essential food;
- access to shelter and housing;
- provision of essential drugs; and
- the adoption of a national public health strategy.

Due to the cross-cutting nature of the right of non-discrimination in art 2(2) of the ICESR, each of these obligations will be assessed with a focus on equitable outcomes to determine whether these core obligations have been met across vulnerable populations.

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67 Waitangi Tribunal *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Wai 2575, 2019) at 30–35.

68 Lawrence O Gostin *Global health law* (Harvard University Press, Cambridge (Mass), 2014) at 263–264.

69 Lisa Montel and others "The Right to Health in Times of Pandemic: What Can We Learn from the UK's Response to the COVID-19 Outbreak?" (2020) 22 Health and Human Rights Journal 227 at 228–229.

A *The content of the core obligations*

The majority of the core obligations focus on access. General Comment 14 defines accessibility with four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility and information accessibility.[70] Non-discrimination means that health care must be accessible to all, in law and in fact, without discrimination.[71] Physical accessibility means that these services must be within "safe physical reach".[72] Economic accessibility is when health facilities, goods, and services are affordable for all.[73] Finally, information accessibility includes the "right to seek, receive, and impart information and ideas concerning health issues".[74]

While accessibility has been defined, the ICESCR has not set out the level of achievement required by states to fulfil their obligations. Human rights scholars have debated heavily whether the core obligations require conduct by states, the achievement of certain results, or a combination of both.[75] An obligation of conduct requires *actions* that are reasonably capable of achieving the desired outcomes. Obligations of result require *achievement* of the desired outcomes.

Audrey Chapman, a professor in medical ethics, proposes a conduct-based interpretation of the core obligations.[76] During discussions with the Committee, she argued that the minimum core obligations should be described as "the minimum duties all State parties set for themselves regardless of the resources available".[77] This focus allows states to control policy priorities and implementation as opposed to requiring a "health development status, which reflect[s] a confluence of many factors, including levels of economic development".[78] Therefore, state parties should have an obligation to establish a set of policies that "enabl[e] them to assure minimum health conditions and thereafter progressively to realize the best possible conditions of physical and mental health".[79] Chapman characterises these obligations as falling within the "respect, protect and fulfil" categorisation.[80] She gives examples of violations of the core obligations, such as failing to focus initiatives on rectifying imbalances in the provision of health services, a violation of the obligation to fulfil.[81] She argues against a results-based interpretation as some states are unable to gather reliable data to measure their progress.

In contrast, other scholars have competing interpretations on the right to health. Maite San Giorgi interprets the right to health as including an obligation to realise the minimum

70 *General Comment 14*, above n 11, at [12].
71 At [12].
72 At [12].
73 At [12].
74 At [12].
75 Forman and others, above n 41, at 537–540. See also *General Comment 3*, above n 42, where obligations of conduct compared to obligations of result was first used by the Committee.
76 Audrey R Chapman "Core Obligations Related to the Right to Health" in Audrey Chapman and Sage Russell (eds) *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (Intersentia, Antwerp, 2002) 185.
77 *Committee on Economic, Social and Cultural Rights: Summary Record of the Forty-Second Meeting* UN Doc E/C12/1993/SR.42 (23 November 1994) at [62].
78 At [62].
79 At [63].
80 Chapman, above n 76, at 205–215.
81 At 212.

core content.[82] The framing of these core obligations as "minimum core content" indicates that these are minimum outcomes that need to be reached, as opposed to an obligation of conduct. David Bilchitz combines obligations of conduct and result, and argues that the core obligations include the principled minimum core and pragmatic minimum thresholds.[83] The principled minimum core is the minimum essential level of the right. However, to avoid unrealistic expectations with the principled minimum core, Bilchitz suggests the use of pragmatic minimum thresholds requiring governments to use policy goal setting to specify minimum levels of services with measurable targets.[84] Finally, Katrina Perehudoff and Lisa Forman suggest the incorporation of a reasonableness standard into the obligation of providing access to essential medicines.[85] Drawing on the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (Optional Protocol),[86] this argument replaces the minimum core with the "right to reasonable action by the state in all circumstances and with particular regard to human dignity".[87]

This article will evaluate New Zealand's COVID-19 strategy based on Chapman's characterisation of the core obligations, with some modifications. A conduct-based interpretation over an obligation of result is favoured because, as Chapman discusses, achievement of outcomes can be difficult to prove without a standardised approach.[88] As Bilchitz also argues, the ability to achieve these obligations to the fullest extent is almost impossible due to the exponential nature of healthcare expenditure.[89] This makes imposing a conduct-based obligation the most realistic interpretation when considering both resources and the nature of healthcare expenditure.

Although the reasonableness standard is based on the Optional Protocol, which New Zealand has not ratified, contrary to Chapman's view, this article argues that the effect of resource constraints should remain a consideration. States can only act within the boundaries of what is available to them. Although General Comment 14 does not support this position, General Comment 3 affirms it when stating that states can justify not meeting these obligations due to a lack of resources. States are required to show that they have tried to use all resources available to them in satisfying these minimum obligations.[90] Without this consideration of resource constraints, states could be required to divert all resources to healthcare.

Further, although Chapman takes a violations approach where she identifies where a state could violate the right to health, this article will use a violation and enjoyment approach. A violations approach looks at failures to comply with the human right and an

82 Maite San Giorgi *The Human Right to Equal Access to Health Care* (Intersentia, Antwerp, 2012) at 32.

83 Daniel Bilchitz *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-economic Rights* (Oxford University Press, Oxford, 2008).

84 At 223.

85 Katrina Perehudoff and Lisa Forman "What Constitutes 'Reasonable' State Action on Core Obligations? Considering a Right to Health Framework to Provide Essential Medicines" (2019) 11 Journal of Human Rights Practice 1 at 5–9.

86 *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights* GA Res 63/117 (2008). This allows parties to bring claims for violations of rights under the ICESCR. State action is assessed based on whether States have taken reasonable measures within their available resources. New Zealand has not ratified this Protocol.

87 Perehudoff and Forman, above n 85, at 5–6 (footnotes omitted).

88 Chapman, above n 76, at 187.

89 Bilchitz, above n 83, at 221.

90 *General Comment 3,* above n 42, at [10].

enjoyment approach looks to the extent that rights are being enjoyed.[91] This combination is preferred because the government implemented many beneficial policies during COVID-19. These remain important considerations when assessing right to health compliance overall.

Aside from the amendments discussed above, Chapman's interpretation of the content of the core obligations will be used as a basis for this article's evaluation framework. This involves evaluating COVID-19 policies through the lens of the obligation to respect, fulfil and protect the core obligations. The Committee has defined these in General Comment 14.[92]

"Respect" requires states to refrain from interfering "directly or indirectly with the enjoyment of the right to health".[93] This includes "refraining from denying or limiting equal access for all persons".[94]

"Fulfil" requires states to adopt measures, whether it be legislative, administrative or budgetary, towards the full realisation of the right to health.[95] It contains three aspects:[96]

- The "facilitate" aspect requires states to "take positive measures that enable and assist individuals and communities to enjoy the right to health".
- The "provide" aspect requires states to provide a "specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves".
- The "promote" aspect requires states to "undertake actions that create, maintain and restore the health of the population". This includes through "ensuring that health services are culturally appropriate".

"Protect" means that states should "take measures to prevent third parties from interfering" with the right to health.[97] This includes "to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties", which involves ensuring that "third parties do not limit people's access to health-related information and services".[98]

V Evaluating New Zealand's COVID-19 Response under the Core Obligations

Using Chapman's interpretation of the core obligations as a framework, this evaluation analyses aspects of the government's response to COVID-19 in relation to these obligations. First, it identifies current inequities in relation to the core obligations (access to healthcare, food, housing and essential medicines; and provision of a national health strategy) that existed prior to COVID-19, and how these inequities worsened during the pandemic. Then, it evaluates selected policies that the government implemented using the respect, fulfil and protect criteria under each core obligation. The evaluation will identify which policies met each criterion and where the government's response could have been strengthened.

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91 Gauthier de Beco "Human Rights Indicators for Assessing State Compliance with International Human Rights" (2008) 77 Nord J Intl L 23 at 31.

92 *General Comment 14,* above n 11, at [33].

93 At [33].

94 At [34].

95 At [33].

96 At [37].

97 At [33].

98 At [35].

The government's initial COVID-19 response began as an elimination strategy that focused on eradicating the virus from the community. Measures included border closures for non-New Zealanders (with exceptions), mandatory isolation for those entering New Zealand and the four-tier alert level system ranging from no restrictions to mandatory lockdowns.[99] As of December 2022, the government has implemented two nationwide lockdowns at Level 4 as well as regional alert level changes.[100] These measures are supported by specially developed legislation and orders.[101] In October 2021, following increased vaccination, New Zealand moved to a virus suppression strategy.[102] This involves a "traffic-light" system, beginning when areas reach 90 per cent vaccination rates, with restrictions depending on whether there are multiple clusters or isolated cases. This system has continued to update as the virus and the government's response progresses.

A *Applying the right to health framework*

(1) Non-discriminatory access and equitable distribution of healthcare

Prior to COVID-19, physical and financial accessibility challenges were already present within the New Zealand health system. Those seeking primary care from general practitioners and nurses faced access barriers, particularly Māori.[103] In 2019, 17 per cent of respondents reported not visiting a GP or nurse due to cost in the previous 12 months.[104] The New Zealand Health Survey also found that Māori were 1.5 times more likely than non-Māori to not see a GP due to cost.[105]

COVID-19 exacerbated these existing access barriers and created additional ones. During the first nationwide lockdown, one study found that more than half of respondents delayed seeking healthcare.[106] This was due to concerns that health services were busy, postponed or unavailable.[107] These additional barriers required the government to address existing access challenges to ensure that healthcare remained available. With many COVID-19 specific facilities (testing and vaccination sites) being in primary care locations (such as pharmacies and GP clinics), it also became imperative for the government to ensure equitable access to COVID-19 specific care.

Applying the evaluation framework, the New Zealand government fulfilled the right to access healthcare by providing health facilities, goods, and services in different ways during COVID-19 lockdowns. One such mechanism was the transition to telehealth services. During regional and nationwide lockdowns, GPs conducted primary care

99 Manatū Hauora "COVID-19: Elimination strategy for Aotearoa New Zealand" (12 August 2021) <www.health.govt.nz>.

100 Unite against COVID-19 "History of the COVID-19 Alert System" (18 August 2021) <https://covid19.govt.nz>.

101 COVID-19 Public Health Response Act 2020; and COVID-19 Public Health Response (Alert Level Requirements) Order (No 9) 2021.

102 Unite against COVID-19 "History of the COVID-19 Protection Framework (traffic lights)" (10 October 2022) <https://covid19.govt.nz>.

103 See Health Quality and Safety Commission New Zealand "Health service access" (3 December 2021) <www.hqsc.govt.nz>.

104 Health Quality and Safety Commission New Zealand, above n 103.

105 Manatū Hauora "Annual Update of Key Results 2019/20: New Zealand Health Survey" (19 November 2020) <www.health.govt.nz>.

106 Fiona Imlach and others "Seeking Healthcare During Lockdown: Challenges, Opportunities and Lessons for the Future" (2022) 11 IJHPM 1316 at 1318.

107 At 1318.

appointments online or over the phone.[108] Manatū Hauora developed rules around electronic prescriptions to assist with the transition to telehealth.[109] One study found that generally, patients were highly satisfied with the virtual method of appointment.[110] Manatū Hauora also set up a free hotline to assist with COVID-19 related questions and medical advice, which addressed information barriers.[111] The shift to greater use of telehealth services alleviated some of the existing access issues such as physical access to primary care and cost of transportation barriers often faced by Māori and Pasifika populations.[112]

The government also fulfilled its obligations under the right to health by introducing community sites for COVID-19 specific vaccination and testing. While primary care providers, such as GP clinics, were available for testing and vaccinations, the government recognised that this did not provide universal access. To address this, community centres were made available in areas with clusters of cases or locations of interest.[113] These centres addressed geographical barriers that existed before the pandemic. Furthermore, both testing and vaccinations were free, directly targeting the barrier of financial access to COVID-19 care.[114]

Increasing funding for Māori health services also fulfilled and respected obligations under the right to health. This initiative increased funding for the Whānau Ora programme, supported Māori health providers through the extension of contracts and guaranteed funding, and increased outreach services for Māori.[115] It has not been evaluated whether these initiatives increased access to healthcare for Māori during COVID-19. However, evaluations of Whānau Ora prior to COVID-19 revealed that targets for whānau engagement were exceeded in most areas from July 2016.[116] Furthermore, using a "Respect" lens, extending contracts with Māori health providers and Whānau Ora meant the government did not interfere with current initiatives that improve access to care for Māori communities.

However, while there were positive steps towards access during COVID-19, these did not eliminate the problems that existed prior to the pandemic. For example, financial access barriers to non-COVID-19 primary healthcare continue to exist, as there have not been initiatives to lower these costs. Further, COVID-19's impact on the labour market has resulted in job losses or a decrease in paid hours that may dull the effect of measures taken to improve access to existing care.[117] This means that prior failures in meeting the

108 Royal New Zealand College of General Practitioners "GPs open for business – but changing the way they see patients" (22 March 2020) <www.rnzcgp.org.nz>.

109 Manatū Hauora "Telehealth and online tools" (Date Accessed: 15 June 2022) <www.health.govt.nz>. Please note that Manatū Hauora has since moved this webpage to the website of Te Whatu Ora.

110 See Fiona Imlach and others "Telehealth consultations in general practice during a pandemic lockdown: survey and interviews on patient experiences and preferences" (2020) 21 BMC Family Practice 269.

111 Manatū Hauora "Healthline" (25 October 2022) <www.health.govt.nz>.

112 Health Quality and Safety Commission New Zealand, above n 103.

113 Unite against COVID-19 "Community Testing Centres" (Date Accessed: 2 September 2021) <https://covid19.govt.nz>; and Unite against COVID-19 "Get your COVID-19 vaccination" (Date Accessed: 12 November 2021) <https://covid19.govt.nz>.

114 Unite against COVID-19 "How to get a COVID-19 test" (20 December 2022) <https://covid-19.govt.nz>; and Manatū Hauora "COVID-19 vaccines" (9 February 2023) <www.health.govt.nz>.

115 Manatū Hauora *Updated COVID-19 Māori Response Action Plan* (July 2020) at 18–19.

116 Te Puni Kōkiri *Whānau Ora Summary Report: 1 July 2016 – 30 July 2017* (2018) at 30. Whānau engagement was measured by the number of whānau who utilised Whānau Ora services.

117 Michael Fletcher, Kate C Prickett and Simon Chapple "Immediate employment and income impacts of Covid-19 in NZ: evidence from a survey conducted during the Alert Level 4 lockdown"

core obligations to health around access have increased the challenges facing the New Zealand healthcare system in a time of crisis and potentially exacerbated the human and financial costs of the pandemic.

(2) Access to minimum essential food

Food insecurity, or food poverty, has existed in New Zealand prior to COVID-19. The New Zealand Health Survey found that in 2015/2016, almost one in five children lived in a food-insecure household, which is defined as a household without enough appropriate access to food.[118] In 2019, the Auckland City Mission estimated that 10 per cent of New Zealand's population was food insecure. Women, Māori and Pasifika were overrepresented in this estimate.[119]

During COVID-19, the rate of food insecurity increased due to the lack of available food and the consumers' ability to purchase it. Global supply chain issues caused shortages, which impacted access to food in New Zealand.[120] New Zealanders' ability to purchase food also decreased due to the economic effects of the pandemic. Reports from charities and community groups revealed a significant increase in demand at food banks. The Salvation Army reported that the demand for food parcels in a week was now the same as their usual monthly demand,[121] while Auckland City Mission increased their estimate of food insecurity to 20 per cent of New Zealanders.[122]

Increased demand for Work and Income New Zealand emergency food grants also reflected an increase in food insecurity. Prior to the first nationwide lockdown, the Ministry of Social Development made 30,000 Special Needs Grants weekly.[123] During the lockdown period, this increased and peaked at 72,000 in one week.[124] The Ministry of Social Development's report on the impacts of COVID-19 on one-off grants found that this increase was likely due to challenges such as reduced access to free or low-cost food (including community or school providers), temporary shortages for food and inflationary pressures.[125]

During the pandemic, the government fulfilled this core obligation by implementing policies that provided economic support to purchase minimum essential food. These policies included increasing existing welfare payments.[126] Temporarily lifts on income limits for Hardship Support were also implemented so that it was "easier for low income

(2020) 56 New Zealand Economic Papers 73 at 77; and Stats NZ "COVID-19 lockdown has widespread effects on labour market" (5 August 2020) <www.stats.govt.nz>.

118 Manatū Hauora *Household Food Insecurity Among Children: New Zealand Health Survey* (June 2019) at 7.

119 Auckland City Mission *Shining the light on food insecurity in Aotearoa* (2019) at 3.

120 See OECD *Food Supply Chains and COVID-19: Impacts and Policy Lessons* (2 June 2020).

121 Sarah Robson "Most people turning to Salvation Army are doing so for the first time" (24 April 2020) Radio New Zealand <www.rnz.co.nz>.

122 Caitlin Neuwelt-Kearns *Aotearoa, land of the long wide bare cupboard: Food Insecurity in New Zealand Part 6 – An outbreak of hunger: the spread of food insecurity in a time of COVID-19* (Child Poverty Action Group, June 2020) at 3.

123 Daniel Frischknecht *Evidence Brief: The impacts of COVID-19 on one-off hardship assistance* (Ministry of Social Development, July 2020) at 4.

124 At 4.

125 At 5.

126 At 1–2 and 7.

workers to receive assistance for items such as food".[127] The government also introduced COVID-19 specific relief funds, including the Resurgence Support Payment and Wage Subsidy Scheme.[128] These schemes targeted businesses that lost a percentage of revenue following the change in alert levels.

While these schemes were generally successful, a study on the impacts of COVID-19 on low-income New Zealanders found that individuals continued to rely on community groups to provide food parcels and other support.[129] This is consistent with studies into the pre-COVID welfare system, which concluded that it was inadequate to cover essential living costs.[130] Rather than applying for additional assistance, respondents relied on family support or community resources.[131] During the pandemic, it remained unclear whether the government's additional welfare increases made up for the shortfall in essential living costs. This suggests that the government needed to support community organisations both prior to and during the pandemic.

Recognising this need for community organisations, the government provided funding to community food service providers, showing a fulfilment of this core obligation. Additional funding was redirected to foodbanks to support food parcel provision.[132] In August 2021, the government announced a $7 million boost for food security networks that operated during the second Level 4 nationwide lockdown. This funding was earmarked for the distribution of 60,000 food parcels and 10,000 wellbeing packs, including to organisations such as the Auckland City Mission and the Salvation Army.[133] Whether this additional funding has been given to those providers who target Māori and Pasifika communities remains unclear.

While these policies were implemented towards fulfilling the obligation to ensure access to minimum essential foods, questions also arose around the obligation to protect. COVID-19 supply chain issues have had a global impact.[134] Reports of price inflation by supermarkets have increased, particularly during lockdowns. In a statement to the media, the Ministry of Business, Innovation and Employment (MBIE) reported that they received 34 enquiries into price gouging on essential goods and services in the first week of the August 2021 lockdown. This rose to 419 by mid-September, with enquiries mostly concerning grocery items.[135] MBIE addressed this through the Price Watch form, launched in March 2020 to monitor price increase enquiries during COVID-19.[136] Upon discovering substantiated claims, the obligation to protect requires the government to act if access to food is threatened by third-party activities such as price gouging.

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127 Carmel Sepuloni "Government extends hardship assistance for low income workers" (press release, 22 October 2021).

128 Employment New Zealand "COVID-19 financial support" (Date Accessed: 2 March 2022) <www.employment.govt.nz>.

129 Kimberley Choi and others "Life during lockdown: a qualitative study of low-income New Zealanders' experience during the COVID-19 Pandemic" (2021) 134(1538) NZMJ 52.

130 Ministry of Social Development *Families and whānau and the benefit system – A high-level initial briefing* (May 2018) at 15.

131 At 15.

132 Frischknecht, above n 123, at 8.

133 Carmel Sepuloni "Government continues to respond to food demand at Alert Level 4" (press release, 28 August 2021).

134 OECD, above n 120.

135 Esther Taunton "More questions over supermarkets' lockdown pricing as tasty cheese hits $20 a kilogram" (19 September 2021) Stuff <www.stuff.co.nz>.

136 Ministry of Business, Innovation and Employment "MBIE'S COVID-19 response" <www.mbie.govt.nz>.

As with access to healthcare, the need for these extra provisions due to COVID-19 indicate that the government did not meet this core obligation prior to the pandemic. Whether these policies will continue in the long term is uncertain, with top-ups to welfare payments being described as only temporary.[137] The core obligations require that policies, such as the ones introduced, should already have been in motion. With the existing issue of food insecurity disproportionately affecting Māori and Pasifika, more support should have been provided to target these communities specifically. The government should focus on Māori and Pasifika community organisations to ensure this inequity is addressed.

(3) Access to shelter and housing

Even before COVID-19, New Zealand had a severe housing shortage and struggled to meet this core obligation. Over 100,000 people identified as being "severely housing deprived" in the 2018 census, which amounts to almost 2.2 per cent of the population—including those who lived in "[u]ninhabitable housing".[138] Severely housing-deprived individuals live in inadequate housing due to a lack of access to housing that meets the minimum standard.[139] Uninhabitable housing is defined as lacking one or more basic amenities, such as drinkable tap water, electricity or a toilet.[140] The New Zealand definition of homelessness includes both severely housing-deprived individuals and those living in uninhabitable housing.[141] Rates of severe housing deprivation include a disproportionate number of Māori, Pasifika and Pasifika young people.[142]

COVID-19 posed an extra level of risk to the homeless population due to greater potential exposure to the virus. Furthermore, access to shelter and housing remains a significant concern as lockdowns leave displaced persons with few options.[143] To support this vulnerable group, the government announced over $100 million in funding to ensure an additional 1,600 motel units for people to be housed in until long-term housing could be secured.[144] This increased funding during the COVID-19 outbreak shows the New Zealand government taking significant steps towards fulfilling their obligation through providing housing for those who are unable to realise this right. An increase in support of the homeless population also suggests that COVID-19 may have brought on a shift from viewing the homeless population as a threat, to a focus on how outside factors can threaten them.[145]

Coinciding with emergency COVID-19 funding, the government also released a non-COVID-19 specific action plan to support homeless and near-homeless populations.[146] This

137 Sepuloni, above n 127.
138 Kate Amore, Helen Viggers and Philippa Howden-Chapman *Severe housing deprivation in Aotearoa New Zealand, 2018* (He Kāinga Oranga – Housing & Health Research Programme , June 2021) at 4.
139 At 8.
140 At 15 and 28.
141 At 28.
142 At 4.
143 Choi, above n 129, at 60–61.
144 Megan Woods "Keeping vulnerable people housed" (press release, 26 April 2020).
145 Cameron Parsell, Andrew Clarke and Ella Kuskoff "Understanding responses to homelessness during COVID-19: an examination of Australia" (2023) 38 Housing Studies 8.
146 Ministry of Housing and Urban Development *Aotearoa/New Zealand Homelessness Action Plan: Phase One 2020–2023* (13 February 2020) at 1–2.

plan includes increasing the number of transitional housing places,[147] a 25 per cent income payment for those staying in motels for longer than seven days, and over $70 million for programmes to prevent homelessness and supporting people into permanent accommodation.[148] This action plan will continue from 2020 to 2023 and includes action points relating to the prevention of homelessness, supply of homes and support for those experiencing homelessness.[149] While housing access was something the government should have already considered, the action plan is not COVID-19 specific. As a result, support for the homeless population will continue after lockdown-specific support ends. The plan's focus on prevention is also promising in terms of its long-term efficacy, as it includes a key focus on partnership with iwi and hapū.[150]

On the other hand, the government has arguably failed to address overcrowding, particularly during lockdowns. This indicates a violation of the provide and facilitate aspects of fulfilment. Household overcrowding is when the number of people in a household exceeds its capacity.[151] Overcrowding was an existing issue prior to the pandemic, with around one in nine New Zealanders living in a crowded household in 2018.[152] Pasifika are more likely to be in crowded households, with about two in five living in a crowded house.[153] For Māori, this rate is about one in five.[154]

Overcrowded housing significantly increases the risk of COVID-19 spread,[155] along with the strain on wellbeing during lockdowns.[156] Those living in crowded homes have expressed that "[i]t's very stressful and I don't get any sleep because I'm paranoid" and "[i]t's not nice, it feels uncomfortable".[157] However, there does not appear to be any policies aimed at supporting those living in these situations during the pandemic, with stories such as:[158]

> We are on the [Kāinga Ora] register for nine months now, and called them but haven't had any help. We've applied for private rentals but haven't heard back. It's hard.

Overcrowding largely stems from the lack of affordable housing.[159] Acknowledgement of this issue has led to creation of the Public Housing Plan, which is set to build 8,000 public and transitional housing places through Budget 2020 funding.[160] While such initiatives

147 At 42; and Ministry of Housing and Urban Development "Transitional housing" <www.hud.govt.nz>. Transitional housing can include new builds, residential homes and long-term leased properties.

148 Jacinda Ardern, Megan Woods and Kris Faafoi "Government steps up action to prevent homelessness" (press release, 13 February 2020).

149 Ministry of Housing and Urban Development, above n 146, at 1–2.

150 At 50–53.

151 Stats NZ "Almost 1 in 9 people live in a crowded house" (22 April 2020) <www.stats.govt.nz>. Capacity can be measured by floor area or number of bedrooms.

152 Stats NZ, above n 151.

153 Stats NZ, above n 151.

154 Stats NZ, above n 151.

155 Khansa Ahmad and others "Association of poor housing conditions with COVID-19 incidence and mortality across US counties" (2020) 15(11) PLoS ONE 1 at 2.

156 Eva Corlett "Covid-19 lockdown tough on overcrowded households" (15 April 2020) Radio New Zealand <www.rnz.co.nz>.

157 Corlett, above n 156.

158 Corlett, above n 156 (alterations in original).

159 Habitat for Humanity New Zealand "the need in New Zealand" <https://habitat.org.nz>.

160 Ministry of Housing and Urban Development *Public Housing Plan 2021–2024* (21 January 2021).

provide hope for the future, they also highlight the shortcomings of previous governments in meeting this core obligation.

(4) Provision of essential drugs

This core obligation relates to the provision of essential drugs identified by the World Health Organisation Action Programme on Essential Drugs. This list is updated every two years and has not been updated since 2019. However, the COVID-19 vaccine would fall under this category.[161]

Prior to COVID-19, New Zealand had existing challenges regarding equitable provision of essential medicines. While there are a range of disparities in essential medicines, this section will focus on vaccinations as General Comment 14 lists immunisation against infectious diseases as an obligation of comparable priority.[162] Lower rates of child vaccinations and the influenza vaccine reveal systemic inequality. Children of Māori, Pasifika and "other" ethnicity have lower immunisation coverage at six months of age compared to New Zealand European and Asian children.[163] Immunisation coverage at two years has declined for Māori from 93 per cent in 2015/16 to 88 per cent in 2018.[164] Rates of influenza vaccine uptake have also been historically lower for Māori. Although there was an improvement in 2020 influenza vaccination rates due to measures such as the "More than just a jab" programme, there remained an 8.4 per cent disparity between the vaccination rates of Māori and non-Māori/non-Pasifika over the age of 65.[165] For the COVID-19 vaccine rollout to be effective, the government needed to address existing challenges in reaching already vulnerable populations.

The government initially rolled out the vaccination plan in four groups.[166] Groups One to Three included those at higher risk of contracting the virus due to their occupation, age or underlying health conditions. Group Four was then split into five age categories. There was a small degree of prioritisation for Māori and Pasifika in this initial rollout, with Group Three including Māori and Pasifika over the age of 60, whereas non-Māori and non-Pasifika aged over 60 were in Group Four.[167] However, this initial vaccination plan violated the obligation to respect as it disproportionately prevented Māori and Pasifika from accessing the vaccine due to their younger population.[168]

Aside from the initial vaccine rollout strategy, the government also introduced specific policies that targeted access to the COVID-19 vaccine. One aspect of the government's vaccine policy that fulfilled this core obligation was community vaccination centres and mass vaccination events. Vaccinations were offered in areas outside of primary care facilities, such as churches or community halls. Despite these efforts, Māori and Pasifika community leaders continued to highlight that the vaccine policy was not working for these

161 Sharifah Sekalala and others "An intersectional human rights approach to prioritising access to COVID-19 vaccines" (2021) 6(2) BMJ Global Health 1 at 3.

162 *General Comment 14*, above n 11, at [43].

163 Immunisation Advisory Centre *National Immunisation Coverage for New Zealand* (University of Auckland, 23 August 2018) at 1.

164 At 1.

165 Nan Wehipeihana and others *More than just a jab: Evaluation of the Māori influenza vaccination programme as part of the COVID-19 Māori health response* (Manatū Hauora, December 2020) at 14.

166 Manatū Hauora "COVID-19: The vaccine rollout" (23 August 2021) <www.health.govt.nz>.

167 Manatū Hauora, above n 166.

168 Manatū Hauora "Age structure" (2 August 2018) <www.health.govt.nz>; and Stats NZ "Pacific Peoples ethnic group" (2018) <www.stats.govt.nz>.

groups,[169] as evidenced by slower vaccination rates for Māori and Pasifika.[170] Targeted schemes such as mass vaccination events did not have the intended effect. For example, in a mass vaccination drive in Manukau, only 1,061 out of 16,000 who received their first COVID-19 vaccine were Māori and only 1,301 were Pasifika.[171]

Vaccine hesitancy may be responsible for some of this lack of uptake. One study found that 64 per cent of Māori participants and 69 per cent of Pasifika participants intended to receive the vaccine compared to 76 per cent of European New Zealanders.[172] A study on child vaccination safety agreement found that Māori and Pasifika may feel greater levels of vaccine hesitancy due to limited access to healthcare, leading to insufficient information about vaccines, negative experiences with health professionals and the relationship between religion and vaccines.[173]

However, vaccine hesitancy is only one of many barriers. Another study into COVID-19 vaccine hesitancy found that ethnicity was not significantly associated with vaccine hesitancy when factors such as socioeconomic status were controlled during modelling.[174] This means that there are other barriers to healthcare disproportionately affecting Māori and Pasifika that prevented them from accessing the vaccine.

Thus, policies solely focusing on vaccine hesitancy may not produce equitable outcomes. As discussed earlier, the initial age-based rollout did not account for the younger population demographics of Māori and Pasifika. Another barrier was that the online booking system could only be accessed with a stable internet connection.[175] Travel was also a financial and physical barrier. This is not surprising, as a study conducted prior to the rollout found that travel time thresholds to different types of vaccination centres disproportionately affected Māori, Pasifika, and lower-income residents.[176] This disparity stemmed from inequitable access to health facilities pre-pandemic. However, free travel initiatives to vaccination centres were implemented later in the rollout.[177]

These challenges show the importance of the promotion aspect of fulfilment, which includes ensuring culturally appropriate care. Community providers have been crucial in addressing these barriers. For example, a Pasifika Vaccination Day Festival was held in Wellington by the Capital and Coast District Health Board in partnership with the Pacific Island Presbyterian Church.[178] The Whānau Ora Commissioning Agency and Te Whānau o Waipareira also launched a "Fight for your Whakapapa" campaign. This campaign aimed

169 Christine Rovoi "Community leaders say govt's vaccine rollout plan is not working for Pasifika" (24 August 2021) Radio New Zealand <www.rnz.co.nz>; and Radio New Zealand "Māori and Pacific health groups worried by low vaccination rate" (9 August 2021) <www.rnz.co.nz>.

170 Manatū Hauora "COVID-19 Vaccine data" (27 August 2021) <www.health.govt.nz>.

171 Torika Tokalau "Covid-19: Mass vaccination event didn't work for Pasifika, pop-up centres better – minister" (14 August 2021) Stuff <www.stuff.co.nz>.

172 Jagadish Thaker "The Persistence of Vaccine Hesitancy: COVID-19 Vaccination Intention in New Zealand" (2021) 26 Journal of Health Communication 104 at 108.

173 Carole H J Lee and Chris G Sibley "Ethnic disparities in vaccine safety attitudes and perceptions of family doctors/general practitioners" (2020) 38 Vaccine 7024 at 7028.

174 Kate C Prickett, Hanna Habibi and Polly Atatoa Carr "COVID-19 Vaccine Hesitancy and Acceptance in a Cohort of Diverse New Zealanders" (2021) 14 The Lancet Regional Health – Western Pacific 1 at 4.

175 Radio New Zealand "Māori Covid-19 vaccination rates lag due to 'access and availability', leaders say" (3 September 2021) <www.rnz.co.nz>.

176 Jesse Whitehead and others "Will access to COVID-19 vaccine in Aotearoa be equitable for priority populations?" (2021) 134(1535) NZMJ 25.

177 Auckland Transport "Free-Vaccine-Travel" (2021) <https://at.govt.nz>.

178 Matthew Tso "Festival atmosphere as capital's Pasfika community gets Covid jabs" (2 July 2021) Stuff <www.stuff.co.nz>.

to provide a whānau-first vaccination response through drive-through vaccinations, walk-ins, and mobile clinics that provided vaccinations to hard-to-reach communities.[179] A government initiative called "Super Saturday" mobilised communities for a nationwide vaccination drive, leading to 130,000 vaccinations in one day.[180] The success of using a whānau-centred approach to increase COVID-19 vaccination rates shows how government-community partnership campaigns can have a positive impact.[181]

Further evidence of the obligation to fulfil, particularly when focusing on vulnerable groups, includes funding to support vaccinations in these communities. On 2 September 2021, the government announced that it would invest $26 million to support Pasifika communities during the Delta outbreak, including through Pasifika vaccination services.[182] Likewise, the COVID-19 Vaccine Programme Māori Implementation Strategy was launched, which included $11 million in funding for Māori health providers, $24.5 million for community-based vaccine support, $1.5 million for the health workforce and $2 million for iwi communications.[183]

The government could have improved their protection of access to essential medicines. Protection of this obligation means protecting the right to health from the actions of third parties. The rhetoric of "anti-vaxxers" that often circulates on social media should be seen as a third-party threat to the fulfilment of this obligation. Anti-vaccination views can contribute to the already present vaccine hesitancy felt by many. To address this, the government has continued to disseminate accurate vaccination advice through advertisements and media. The COVID-19 website includes advice for users to detect false information.[184] CERT New Zealand also has a reporting service for COVID-19 scams and misinformation.[185] However, despite these measures, there continues to be a high level of hesitancy due to misinformation which indicates that more should be done, such as reaching out to communities with higher vaccine hesitancy.

New Zealand's vaccination situation is constantly evolving. Since the August 2021 Delta outbreak and subsequent shift from elimination to containment, there has been an increased push for New Zealanders to get vaccinated. Policies that utilised community groups and targeted vulnerable groups were developed. However, these were implemented only after it became apparent that the existing rollout was not reaching Māori and Pasifika communities to the same extent as other communities. The early lack of focus on vaccinating these groups, combined with factors such as household overcrowding, resulted in the majority of cases being Māori and Pasifika in the August Delta outbreak. This shows the consequences of the initial vaccination rollout strategy.

179 Whānau Ora and Te Whānau o Waipareira "Fight for your whakapapa" <www.fightforyourwhakapapa.co.nz>.

180 Manatū Hauora "Super Saturday COVID-19 vaccination data update" (press release, 17 October 2021).

181 Wehipeihana and others, above n 165, at 6.

182 Aupito William Sio "Major boost to support the Pacific Community in the face of Covid-19" (press release, 2 September 2021).

183 Manatū Hauora *COVID-19 Māori Vaccine and Immunisation Plan: Supplementary to the Updated COVID-19 Māori Health Response Plan* (26 March 2021) at 8 and 10–11.

184 Unite against COVID-19 "Misinformation, scams and online harm" (16 December 2021) <https://covid19.govt.nz>.

185 CERT New Zealand "Report COVID-19 vaccine scams or misinformation" <www.cert.govt.nz>.

(5) National public health strategy

This core obligation requires states to adopt and implement a national public health strategy. General Comment 14 specifies that states should base this strategy on "epidemiological evidence, addressing health concerns of the whole population".[186] A plan of action should also be developed and reviewed through a participatory and transparent process. These should include right to health indicators and benchmarks, with particular attention to vulnerable and marginalised groups.[187]

Prior to COVID-19, New Zealand had a National Health Strategy and an accompanying roadmap in place.[188] These set out the future direction for the New Zealand health system from 2016 to 2026 and aimed for "[a]ll New Zealanders [to] live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system."[189]

As is required through this core obligation, specific strategies for vulnerable groups were also present. This included He Korowai Oranga: Māori Health Strategy[190] and Whakamaua: Māori Health Action Plan 2020–2025.[191] He Korowai Oranga gives a high-level framework to assist the government to achieve the best health outcomes for Māori. Whakamaua sets priority areas for action and was developed alongside an Expert Advisory Group. This group includes Māori academics, health professionals, iwi and rangatahi leaders. [192] For Pasifika health, the government developed Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025.[193] The overall goal is to ensure that Pasifika families thrive in New Zealand. This includes guiding principles to reflect Pasifika values which were developed through consultation, or *talanoa*, with Pasifika communities.[194]

During COVID-19, the government continued to fulfil this core obligation as they developed specific strategies. When the first virus outbreak occurred in New Zealand, Manatū Hauora released the COVID-19 Health and Disability System Response Plan.[195] This plan reinforced the commitment to Te Tiriti and its application to COVID-19 responses.[196] It also emphasised equity as being the centre of the national response, showing an intention for vulnerable and marginalised groups to be recognised during the response.[197] As the pandemic continued, the government implemented the elimination strategy,[198] and the surveillance strategy.[199]

Specific COVID-19 strategies for Māori and Pasifika have also been developed, including the Māori Health Response Plan.[200] The plan has three objectives across the

186 *General Comment 14*, above n 11, at [43].
187 At [57].
188 Manatū Hauora *The New Zealand Health Strategy: Future direction* (April 2016); and Manatū Hauora *New Zealand Health Strategy: Roadmap of actions 2016* (April 2016).
189 Manatū Hauora *The New Zealand Health Strategy: Future direction,* above n 188, at 13 (emphasis omitted).
190 Manatū Hauora "He Korowai Oranga" (17 December 2020) <www.health.govt.nz>.
191 Manatū Hauora *Whakamaua: Māori Health Action Plan 2020–2025* (July 2020).
192 At 64–65.
193 Manatū Hauora *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025* (June 2020).
194 At 15.
195 Manatū Hauora *COVID-19 Health and Disability System Response Plan* (April 2020).
196 At 10.
197 At 13.
198 Manatū Hauora, above n 99.
199 Manatū Hauora *Aotearoa New Zealand's COVID-19 Surveillance Strategy* (August 2021).
200 Manatū Hauora *Updated COVID-19 Māori Health Response Plan* (July 2020).

COVID-19 response: ensure that Māori communities can exercise their authority to respond to health challenges; ensure that the health system delivers equitable outcomes; and ensure that Te Tiriti and Māori health equity responsibilities are met.[201] The Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025 contains details about the Pasifika COVID-19 response. The objectives that guide the pandemic response work include: providing guidance to Manatū Hauora's COVID-19 response so that it meets the needs of Pasifika communities, engaging Pasifika health sector leaders and mobilising providers to Pasifika communities.[202]

These specific plans meet the aspect of this core obligation that requires the adoption and implementation of strategies focusing on marginalised or vulnerable groups. However, the government fails to meet this core obligation through the exclusion of right to health benchmarks and indicators. Indicators relating to access to healthcare were included in pre- and during COVID-19 plans, as shown in the New Zealand Health Strategy's goal of bringing services "closer to home" and Ola Manuia's goal of mobilising providers to Pasifika communities.[203] However, these plans do not reflect all aspects of the core obligations, nor is there mention of specific right to health goals or monitoring in the plans discussed in this article. While the Human Rights Commission has a National Plan of Action relating to New Zealand's human rights record, this does not contain all aspects of the core obligations. A separate strategy is required.[204]

Chapman identifies this failure as a violation of the core obligations. She lists "[f]ailure to adopt a national health policy with a detailed plan for realising the core minimum of the right to health" as a violation of the "fulfil" requirement.[205] As Chapman discusses, the core obligations require states to develop systematic plans that set goals and timetables for each obligation.[206] States should also seek active consultation and participation with communities. Further, states should monitor and evaluate their progress. This conclusion provides a basis for recommendations going forward.

B *Has New Zealand met its obligations?*

Overall, the government has not met its obligation to protect the right to health of vulnerable communities under the core obligations. While there were improvements during their COVID-19 response, this article has identified failures to live up to right to health expectations during the pandemic. These failures meant that COVID-19 policies did not meet the obligation of conduct and were not capable of achieving desired outcomes. To summarise, the government failed to:

- decrease costs of primary healthcare;
- commit to long-term welfare increases;
- support targeted assistance for Māori and Pasifika communities to access essential food;
- protect food prices, subject to proof of price gouging;
- improve the availability of state housing to address household overcrowding;

201 At 9.
202 Manatū Hauora, above n 193, at 31.
203 Manatū Hauora *The New Zealand Health Strategy: Future direction,* above n 188, at 19; and Manatū Hauora, above n 193, at 31.
204 See Human Rights Commission *New Zealand's National Plan of Action on Human Rights: Te Mahere Rautaki ā-Motu – Final Report for the 2014–2019 UPR cycle* (July 2019).
205 Chapman, above n 76, at 211.
206 At 211.

- protect the public from the anti-vaccination rhetoric to avoid vaccine hesitancy; and
- develop and implement a strategy for fulfilling the right to health.

However, some of these failures were due to pre-existing inequities. These include the need to decrease costs of primary healthcare, support targeted assistance for access to essential food and improve the availability of state housing. The government also had to implement policies and expend more resources during COVID-19 due to pre-existing inequities. Areas where funding increased included community testing and vaccination sites, mobilising community resources for equitable vaccine delivery, increased welfare support, and support for homelessness during lockdowns.

Some of these areas of investment are pandemic-specific. For example, the location of outbreaks required increased access to testing. Welfare support is also bound to increase during a global pandemic as the economy suffers and businesses close. However, a focus on the right to health before the pandemic could have lessened the level of investment required. Homelessness was a key indication of this. The government was required to increase support for the homeless population during lockdowns due to the failure to support these communities prior to the pandemic.

In summary, a pre-pandemic focus on the right to health could have led to less expenditure during the pandemic and prevented some aspects of COVID-19 policy falling short of obligations. This justifies the right to health becoming part of health system planning to ensure that policies capable of addressing these inequities are put in place prior to public health crises. To achieve this, New Zealand should implement a human rights-based health system through statutory changes and a national health strategy that contains right to health benchmarks and indicators. This will increase the likelihood of New Zealand meeting its core obligations, creating a strong foundation of health and reducing expenditure for future public health crises.

VI Lessons for the New Health System

As this article's evaluation has revealed, the need for the right to health to inform the planning and operation of the new health system will be crucial in ensuring New Zealand is prepared for future crises. In 2005, then United Nations Secretary-General, Kofi Annan, said to the United Nations Commission on Human Rights:[207]

> For much of the past 60 years, our focus has been on articulating, codifying and enshrining rights. … But the era of declaration is now giving way, as it should, to an era of implementation.

It is necessary to begin this era of implementation to ensure health system preparedness and reduce the need for excess expenditure during future pandemics. Existing health inequities resulted in high levels of expenditure during COVID-19. This expenditure could have been lessened had the government set right-to-health-based goals earlier. Therefore, the system can best prepare for future public health emergencies by implementing an approach consistent with a right to health framework into health system reforms.

207 United Nations "Secretary-General's Address to the Commission on Human Rights" (7 April 2005) <www.un.org>.

The government's new health reforms aim to strengthen the health system into a single nationwide health service that provides consistent, high-quality services.[208] These reforms are supported by the Pae Ora (Healthy Futures) Act, which establishes the new entities in the system, their roles and other health documents. There are three key organisations within this new system: Manatū Hauora, Te Whatu Ora, and Te Aka Whai Ora. Manatū Hauora will lead in strategy and policy as the steward of the health system. Within Manatū Hauora sits the Public Health Agency, which leads public health policy, strategy and surveillance functions.[209] Te Whatu Ora represents a consolidation of existing District Health Boards and will lead healthcare operations and delivery.[210] Te Aka Whai Ora will focus on Māori in the health system and work with Manatū Hauora and Te Whatu Ora.[211] Regarding specific services for Pasifika, Manatū Hauora also includes a Pacific-led capability.[212] This capability will have senior Pasifika leadership that advises Ministers, supporting accountability for Pasifika outcomes. These organisations will be important for future pandemic planning.

Incorporating the right to health into the new health system will involve:

- strengthening the right to health in health and disability legislation; and
- developing specific measures and indicators relating to the core obligations in a right to health strategy.

A *Implementing a human rights-based approach*

Although New Zealand has ratified the right to health through the ICESCR, there remains no explicit recognition of the right in legislation. As discussed in Part II, aspects of the right to health are featured in various domestic statutes. Researchers have also found that 63 countries recognise the right to health in their constitution, bill of rights or other statutes.[213]

While New Zealand does not have a written constitution, it remains important to codify the right to health into existing legislation to ensure that health organisations are guided by this right in their planning. A right to health mandate should be included in the purpose section of the Pae Ora (Healthy Futures) Act. This mandate should be incorporated by including an objective to fulfil, respect and promote the right to health, with the right defined as the right to the highest attainable level of health, mirroring the ICESCR. As the Pae Ora (Healthy Futures) Act is a central feature of the new system, this move will safeguard a right to health focus going forward.

While the inclusion of the right in the purpose section of the Pae Ora (Healthy Futures) Act appears to weaken its role when compared to other jurisdictions, doing so would allow the government to be guided by the right, within the bounds of their resources. The Human Rights Commission and the Committee have called for strengthened protections of cultural, economic and social rights. They argue that rights from the ICESCR do not have

208 Andrew Little *The Health and Disability System Review: Proposals for Reform* (Department of the Prime Minister and Cabinet, CAB-21-SUB-0092, March 2021).

209 At 18.

210 At 2 and 16.

211 At 15.

212 At 23.

213 Gunilla Backman and others "Health systems and the right to health: an assessment of 194 countries" (2008) 372 Lancet 2047 at 2075. See, for example, Constitution of the Republic of South Africa 1996, art 27; Constitution of Kenya 2010, art 43; and Constitution of the Dominican Republic 2015, art 61.

the same recognition as civil and political rights, which are contained in the NZBORA.[214] Despite this, the government has indicated it has no plans to review the NZBORA.[215] One reason for this may be the perception that incorporation of the right to health within the NZBORA will open up avenues for litigation.[216] While litigation would act as an external accountability mechanism, the broad nature of the right to health means there is high potential for unmeritorious claims. In a system with limited resources, it may never be possible to fully realise all care required by the right to health. However, full consideration of the potential impact of incorporating the right to health into the NZBORA and its justiciability are points for further research.

B *Developing right to health measures and indicators*

The evaluation of the core obligation to implement a national health strategy revealed that there is no specific strategy relating to the right to health in New Zealand. However, aspects of the right to health exist in other action plans, such as the National Health Strategy and the Homelessness Action Plan. To create a right-to-health-based strategy, Manatū Hauora should develop a series of measurable indicators that encompass all aspects of the core obligations to allow for assessment and iterative progress. A human rights indicator can be defined as:[217]

> … specific information on the state or condition of an object, event, activity or outcome that can be related to human rights norms and standards; that addresses and reflects human rights principles and concerns; and that can be used to assess and monitor the promotion and implementation of human rights.

Human rights indicators ensure that state practice can be monitored. As discussed previously in Part IV, while the preferred interpretation of the core obligations does not require certain obligations of result to be met, it remains important to continually monitor progress.

Good practice guidelines for the development of human rights indicators progress through a series of stages. These are:[218]

- [e]stablishing the purpose of the indicators;
- [d]esigning the conceptual framework;
- [s]electing and designing the indicators;
- [i]nterpreting and reporting the indicators; and
- [m]aintaining and reviewing the indicators.

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214 Human Rights Commission *Economic, Social and Cultural Rights in New Zealand: Submission of the Human Rights Commission for the Fourth Periodic Review of New Zealand under the International Covenant on Economic, Social and Cultural Rights* (15 February 2018) at 4; and *Concluding observations*, above n 55, at [6].

215 *Fourth periodic report*, above n 54, at [8].

216 See Oscar A Cabrera and Ana S Ayala "Advancing the right to health through litigation" in José M Zuniga, Stephen P Marks and Lawrence O Gostin (eds) *Advancing the Human Right to Health* (Oxford University Press, Oxford, 2013) 25 at 31–33 for a discussion about the different factors that may lead to greater Right to Health litigation.

217 Office of the United Nations High Commissioner of Human Rights *Human Rights Indicators: A Guide to Measurement and Implementation* (January 2012) at 2 (emphasis omitted).

218 Denise Brown *Good Practice Guidelines for Indicator Development and Reporting* (OECD, October 2009) at 1.

Due to the function of each of the new agencies, Manatū Hauora, with the Public Health Agency as a unit within it, would be the most appropriate authority to oversee the development of this strategy, alongside Te Aka Whai Ora.

(1) Establishing the purpose of the indicators

The purpose of human rights indicators is to hold state bodies accountable for their human rights obligations.[219] In this case, indicators need to monitor whether New Zealand is meeting the core obligations of the right to health. While the right to health is broader than just the core obligations, the proposed strategy relates to the core obligations as these are the first step towards achieving this right.

Establishing the specific purpose of right to health indicators requires identifying the communities, organisations and individuals involved.[220] Identification must establish key stakeholders, determine whether there will be an expert group for specialist advice and who will be responsible for the final selection and publication of the indicators. Here, the key stakeholders include Te Whatu Ora and Te Aka Whai Ora. Other key stakeholders are Māori and Pasifika communities. This means that an expert group, such as the Expert Advisory Group for the Māori Health Action plan should be formed. The existing Expert Advisory Group includes Māori academics, health professionals, iwi and rangatahi leaders. Manatū Hauora should also consult with Pasifika leaders, such as those who will be involved in the strengthened Pasifika capability within Manatū Hauora.

Establishing a strong purpose will set the tone of the strategy and help identify focus areas. Different stakeholders may have different views on what this purpose may be. For example, there may be a conflict between Te Whatu Ora and Te Aka Whai Ora as they have different roles and mandates. In this circumstance, Manatū Hauora should prefer the views of Te Aka Whai Ora as Māori are a key community whose right to health has been impacted, as shown by the evaluation in this article. The right to health indicators should aim to reveal whether the government has complied with the core obligations, particularly with regard to vulnerable communities.

(2) Designing the conceptual framework

The next stage is designing the conceptual framework to provide a "formal way of thinking" to enable a "coherent set of indicators".[221] A conceptual framework allows indicators to be used consistently and reflect the instrument that they are trying to measure.[222] In this case, the overall instrument is the ICESCR, in particular art 12 (the right to health) and art 2 (non-discrimination). To evaluate compliance with the overall right to health, the right should be broken down into its constitutive elements.[223]

The framework should exist broadly around four themes that mirror the core obligations. These are: access to healthcare facilities, goods and services, access to minimum essential food, access to housing and provision of essential medicines. To break down the art 2 obligation of non-discrimination, each outcome will need to be disaggregated. This means that data should be collected about gender, ethnicity and

219 De Beco, above n 91, at 27.
220 Brown, above n 218, at 1.
221 At 2.
222 De Beco, above n 91, at 33.
223 At 33.

region. This is important as disaggregating information reveals actual enjoyment of the right for all citizens.[224]

Within each broad theme, specific outcomes should be identified. Suggested examples of these outcomes are:

- access to health care facilities, goods, and services: physical access, financial access and distribution;
- access to minimum essential food: food availability and food accessibility;
- access to housing: housing availability, affordability, and standard of housing; and
- provision of essential medicines: physical access and financial access.

(3) Selecting and designing the indicators

Selecting indicators in relation to these outcomes should be done in consultation with stakeholders. This means Manatū Hauora needs to consult with the stakeholders identified in stage one. These indicators should be valid and meaningful, grounded in research, intelligible and easily interpreted, linked to policy or emerging issues and related to other indicators.[225] Examples of indicators that are already in use are:

- Access to healthcare facilities, goods and services:[226]
    a. Percentage of the population who live thirty minutes or further from a primary care facility;
    b. Percentage of people who report a time where they were unable to access a GP due to cost;
- Access to minimum essential food:[227]
    a. Food runs out in our household due to lack of money;
        i. How often has this been true for your household over the past year (1) often (2) sometimes (3) never;
    b. We make use of special food grants or food banks when we do not have enough money for food;
        i. How often has this been true for your household over the past year? (1) often (2) sometimes (3) never;
- Access to housing:[228]
    a. Those living without shelter: roofless/rough sleeper, improvised dwellings or mobile dwellings;
    b. Those in shared accommodation: temporary residence in a severely crowded private dwelling, number of people in the home compared to number of rooms; and
- Provision of essential medicines:
    a. Dispensation of 'x' medication by ethnicity compared to need.

These examples come from sources including the Census, the Health Quality and Safety Commission Survey and the New Zealand Health Survey. Data is currently available to develop a right to health strategy and report on New Zealand's progress. This means implementing this strategy will be less resource-intensive. However, these examples also show that developing and collecting data for these indicators will require an inter-agency

224 At 29–30.
225 Brown, above n 218, at 3–4.
226 Health Quality and Safety Commission New Zealand, above n 103; and Manatū Hauora, above n 105.
227 Manatū Hauora, above n 118.
228 Amore, Viggers and Chapman, above n 138.

effort. This may require working with the Ministry of Housing and Urban Development and the Ministry of Social Development, alongside health organisations.

Despite these indicators seemingly identifying violations of the right to health, they also show the level of enjoyment. The distinction between a violations and enjoyment approach is less relevant for human rights indicators.[229] For example, when an indicator shows that there has been a lack of access for one group, this points towards that group not enjoying their rights.

(4) Interpreting and reporting the indicators

Interpreting and reporting on these indicators bridges the gap between measurement and understanding.[230] This will require analysing these indicators to determine whether New Zealand is meeting the core obligations. Manatū Hauora can then develop a report with input from all stakeholders. With this knowledge, the government can implement policies that focus on identified problem areas. These policies will look similar to what has been done during COVID-19, but with a longer-term focus. For example, if it is reported that a large number of applications for Special Needs Grant for food are made in a certain area, then policies that direct funding to community food banks in that area can be put in place.

(5) Maintaining and reviewing the indicators

Finally, maintaining and reviewing right to health indicators will require discussion with stakeholders and experts.[231] It will be important to continually review and evaluate the right to health, as any indicators that have been chosen may not reflect actual need. Existing mechanisms such as the Human Rights Commission can be used to monitor and review progress. This provides a further mechanism to hold Manatū Hauora and other relevant ministries, such as the Ministry of Social Development, and the Ministry of Housing and Urban Development, accountable. Te Aka Whai Ora is also an important accountability organisation to ensure the right to health of Māori is not neglected.

The government could also consider a complaints process that allows feedback from the public about their right to health. As discussed in Part VI, this article does not suggest that claims for violations of the right to health should be brought before the courts. An informal complaints process would ensure the presence of accountability, while allowing New Zealanders to provide input into how their rights are being upheld. The merits of such a complaints process and its operations are both points for further research.

C *Challenges and further research*

As with any suggestion for change, limitations may arise. First, while a right to health strategy focuses on equity and the protection of vulnerable populations, it should not replace Te Tiriti o Waitangi obligations. A key consideration is how the right to health interacts with and affects rights under Te Tiriti. Te Tiriti is a guiding document for all health organisations and should remain a primary source of obligations. This means it is important to research how the right to health can be used in a way that complements

229 De Beco, above n 91, at 32.
230 Brown, above n 218, at 5.
231 At 6.

Te Tiriti without impeding on the rights of Māori. This may lead to changes such as defining the right to health consistently with Te Tiriti in legislation.

Secondly, the obligations under the right to health may never be achieved. The right to health and its core obligations, like many human rights, are conceptualised in a vague manner. This article took the view that the core obligations are obligations of conduct, subject to resource constraint. However, the lack of certainty about the content of the obligation makes it difficult to assess the degree of enjoyment or violation of the right to health in New Zealand. Without guidance from international bodies, the government must set their own definition of the content of the right, in consultation with stakeholders.

Finally, the efficacy of these suggested changes is also unclear. This will depend on political factors such as the priorities of future governments, the ability of agencies to integrate and share resources and the ability to collect this data in an accurate way. Further, the direct impact of a right to health focus on pandemic preparedness is unknown. Pandemics and other public health emergencies are unpredictable by nature. However, this limitation also exists across all policy and planning. Governments must apply past lessons towards future use, just as this article has done in the evaluation of COVID-19 policies.

VII Conclusion

The COVID-19 pandemic has revealed the shortcomings of health systems and allowed states to identify where these need to be strengthened. In New Zealand, a nation that has done relatively well in its COVID-19 response, these lessons can be learnt through evaluating policies through the right to health. This article chose the core obligations as a framework specifically, as these are obligations of immediate effect and should have been in place prior to the pandemic.

Due to existing health inequities, the government deployed a vast amount of resources to ensure that existing inequities did not worsen significantly during the crisis. While these new policies improved support for vulnerable groups, such as Māori and Pasifika, there were also other areas where policy was insufficient. This included the initial vaccine rollout, lack of policies addressing overcrowding and the lack of a right to health strategy. Overall, pre-existing inequities under the core obligations led to New Zealand not meeting their right to health obligations during their COVID-19 response. A focus on the right to health in the future will promote health system preparedness for pandemics and public health crises.

To address this, New Zealand should create a human rights-based health system. This should be done through implementing a right to health mandate in the Pae Ora (Healthy Futures) Act using the "respect", "fulfil" and "protect" criteria and developing key indicators for a right to health strategy. A suggested methodology for how these indicators can be developed shows that stakeholder engagement and integration between ministries is key. This article's methodology utilised existing indicators and organisations to create a right-to-health-based strategy, making this a practical pathway forward for the future health system. Incorporating these recommendations will assist in future pandemic responses through targeting inequities and promote a higher level of health for all New Zealanders.