DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

The following documents have been proactively released by the Department of the Prime Minister and Cabinet (DPMC), on behalf of the Minister of Health, Hon Dr Ayesha Verrall:

October 2022 Review of Remaining COVID-19 Measures Under the New Approach

The following documents have been included in this release:

Title of paper: October 2022 Review of Remaining COVID-19 Measures Under the New Approach (CAB-22-SUB-0443 refers)

Title of paper: Regulatory Impact Statement: October review of remaining COVID-19 measures under the new approach

Title of minute: October 2022 Review of Remaining COVID-19 Measures Under the New Approach (CAB-22-MIN-0443)

Some parts of this information release would not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act). Where this is the case, the relevant section of the Act that would apply has been identified. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Key to redaction codes:

- Section 9(2)(f)(iv), to maintain the confidentiality of advice tendered by or to Ministers and officials;
- Section 9(2)(g)(i), to maintain the effective conduct of public affairs through the free and frank expression of opinion;
- Section 9(2)(h), to maintain legal professional privilege; and
- Section 9(2)(i), to protect the Crown's commercial activity.

~~In Confidence~~

Office of the Minister for COVID-19 Response

Chair, Cabinet

October review of remaining COVID-19 measures under the new approach

Proposal

1 This paper outlines the options for current public health measures, based on public health advice and non-health impacts.

Relation to Government priorities

2 This paper concerns the Government's response to COVID-19.

Executive Summary

3 In September 2022 we moved away from the COVID-19 Protection Framework (CPF) to a new approach to managing COVID-19 [CAB-22-MIN-0380]. This decision was based on reducing cases, wastewater surveillance detections, hospitalisations, and fatalities due to COVID-19, high vaccination rates, widened access to antivirals, and increased access to free rapid antigen tests (RATs) and masks.

4 We also agreed to remove several mandated measures, including vaccination and post-arrival testing requirements at the border, the remaining employee vaccination mandates, self-isolation for household contacts, and mask requirements except for in healthcare services. Air arrivals were recommended to test on days 0/1 and 5/6 after arrival, and household contacts of COVID-19 cases were recommended to test daily for five days.

5 In September I proposed that all mandatory measures be reviewed in the first week of October 2022. Case counts have now started to increase slightly, while hospitalisation trends and levels of viral particles in wastewater have been relatively constant. The Director-General of Health (the Director-General) considers it likely that New Zealand will experience a further wave of COVID-19 by the end of 2022, either due to waning immunity, new subvariants, and/or behaviour change. There are several subvariants circulating domestically and internationally that appear to have a growth advantage over our predominant BA.5 variant. These include the BQ.1.1 variant recently detected in New Zealand. Based on European data, it appears to have a growth advantage of 10-15 percent.

6 It now appears case numbers may be on the rise again, with a seven-day rolling average of 1,598 for the week ending 9 October rising to a seven-day rolling average of 1,826 by 13 October.

7 The Director-General recommends retaining the status quo of seven-day mandatory self-isolation. Requiring cases to isolate remains our most effective measure to reduce transmission of COVID-19. Its retention also allows for the management of the COVID-19 response while removing or reducing other measures. Lifting isolation requirements may also disproportionately impact Māori, Pacific, socio-economically disadvantaged, older, and disabled communities. Shifting to five days or five days with test-to-release (maximum seven days) was also investigated, however, these options were not considered effective and expected to increase hospitalisations and deaths due to the potential increase in cases infectious at release, which would likely fall disproportionately on the at-risk groups mentioned.

8 The Director-General recommends that current guidance for household contacts to test daily for five days is retained.

9 The Director-General recommends retaining the current government-mandated mask requirements for visitors to healthcare services.

10 The Director-General recommends that the public health requirement for air travellers to New Zealand to provide information using the New Zealand Traveller Declaration (NZTD) for contact tracing purposes is removed.

11 Customs (Arriving Passenger and Crew Declarations) Amendment Rules 2022 will come into force on 5 November 2022 requiring air travellers to provide digital contact and travel history information using the NZTD. Although collection of information under Customs Rules is for Customs purposes, in the event contact tracing of air arrivals for COVID-19 is desired in future, information may be able to be shared with Health agencies in accordance with the Privacy Act 2020, or for contact tracing purposes as necessary under the Health Act 1956. NZTD will remain operational in a voluntary capacity during the two-week gap. People opting not to fill in NZTD would not be able to use the eGates on arrival into New Zealand.

12 For post-arrival testing, the Director-General recommends updating the guidance so that only symptomatic air arrivals are recommended to test. This is considered more proportionate than the current guidance to test on days 0/1 and 5/6.

13 s9(2)(f)(iv) [redacted]

Background

Status of the COVID-19 outbreak

14 As of the week ending 9 October 2022, case counts started to increase slightly in the context of likely lower reporting/testing and overall lower case ascertainment with a seven-day rolling average of 1,598 new reported[1] cases per day nationally; this was a 12 percent increase on the previous week. On 13 October, the seven-day rolling average increased to 1,826.

15 Hospital occupancy trends from COVID-19 have stabilised in the week ending 9 October 2022 and levels of viral particles in wastewater have been overall constant in the recent weeks to 2 October, with some variation regionally.

16 Following new data and intelligence, the Director-General considers that it is likely that New Zealand will experience a further wave of COVID-19 by the end of 2022 either due to waning immunity, new subvariants, and/or behaviour change.

17 Modelling suggests a slow rise in cases to the end of the year. However, this modelling is based on immunity waning alone and does not account for new variants. COVID-19 Modelling Aotearoa is now working on a variant model based on the estimated growth advantage of current variants.

18 Hospitalisations are rising in many countries in Europe. Subvariants are not currently thought to be the primary driver of the increase in hospitalisations and cases in Europe, due to the low prevalence of these new variants at this time. In Canada, hospitalisations are increasing as well, but it is unknown currently whether this is driven by new subvariants. The new subvariants in New Zealand are expected to be associated with an increase in cases in the future.

19 There are several subvariants circulating domestically and internationally that appear to have a growth advantage over our predominant BA.5 variant. BA.2.75 appears to show initial signs of increasing in New Zealand in both whole genome sequencing (WGS) and wastewater.

20 The first case of BQ.1.1 has recently been detected in New Zealand. Based on initial overseas data, the growth advantage of BQ.1.1 is thought to be between 10 and 15 percent. If that proves correct, we would expect to see a rapid increase in case numbers. Due to lack of comprehensive data it is unclear what impact the new variants will have in New Zealand on cases, hospitalisations and deaths, particularly for population groups disproportionately affected by COVID-19 such as older people, disabled people, Māori, Pacific peoples, and some ethnic communities.

Transition to the new approach

21 In September 2022 we moved away from the CPF to the new approach to managing COVID-19 [CAB-22-MIN-0380] based on baseline and reserve measures. This decision was based on reducing cases, wastewater surveillance detections, hospitalisations, and fatalities due to COVID-19, high vaccination rates, widened access to antivirals, and increased access to free RATs and masks.

22 We further agreed in September 2022, that at this stage in our pandemic response it was appropriate to retain some mandatory and non-mandatory measures. The mandatory requirements we retained are:

22.1. Case isolation for seven-days via the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 (the Self-Isolation Order);

22.2. Mask use for visitors to healthcare services via the new COVID-19 Public Health Response (Masks) Order 2022 (the Masks Order);

22.3. Provision of contact details and travel history information for air arrivals using the NZTD for contact tracing purposes via the COVID-19 Public Health Response (Air Border) Order 2021 (the Air Border Order); and

22.4. Regulation of point-of-care tests via the COVID-19 Public Health Response (Point-of-care Tests) Order 2021 (Point-of-care Tests Order).

23 We also removed several mandatory measures, replacing them with guidance, including:

23.1. Household contact daily testing for five days;

23.2. Mask use on public transport (including international flights), and in certain other settings; and

23.3. Post-arrival testing for air arrivals on days 0/1 and 5/6, including a recommendation to get a polymerase chain reaction (PCR) test if positive.

24 We agreed measures would be reviewed in October 2022 in light of public health advice and all-of-government agencies' feedback.

Legal basis for COVID-19 orders

25 The Epidemic Preparedness (COVID-19) Notice 2022 (the epidemic notice) is required to be renewed by 20 October 2022 if there are grounds to retain it. The epidemic notice enables the making and amending of orders under the COVID-19 Public Health Response Act 2020 (COVID-19 Act).

26 The epidemic notice can only be renewed if the Prime Minister is satisfied that the effects of an outbreak of COVID-19 are likely to continue to disrupt essential governmental and business activity in New Zealand (or the parts of New Zealand concerned) significantly. The Director-General has advised she does not consider that the effects of an outbreak of COVID-19 are likely to continue to disrupt essential governmental and business activity in New Zealand (or parts of New Zealand) significantly. As such, the Director-General has recommended that the epidemic notice is not renewed. This recommendation has been reviewed by Crown Law.

27 Without an epidemic notice in force for COVID-19, COVID-19 orders can only be made if there is a state of emergency or transition period in force for COVID-19, or if authorised under section 8(c) of the COVID-19 Act. Under 8(c) the Prime Minister must be satisfied that there is a risk of an outbreak or the spread of COVID-19.

28 When the epidemic notice expires, there will be flow on effects to other legislative instruments in force under the Epidemic Preparedness Act 2006 and legislative provisions enabled through the COVID-19 Response Legislation Acts which will also expire, automatically revoke, or be repealed. This will include the use of audio links in criminal proceedings and civil procedures, and local government attendance at meetings via audio link or audio-visual link.

29 The Department of the Prime Minister and Cabinet has provided advice to the Prime Minister and other relevant Ministers on section 8(c). s9(2)(h)

s9(2)(h)

COVID-19 measures in place in other countries

30 In September 2022, I advised on the comparable case isolation requirements remaining in other countries, namely Australia, Denmark, Ireland, the Netherlands, and Singapore (which each had between three- and seven-day minimum isolation periods), with the United Kingdom being the notable exception having removed case isolation requirements.

31 Since then, Australia has announced the removal of mandatory case isolation from 14 October 2022. A limited number of individuals in Australia will still be able to access asset tested financial support. This support is restricted to casual workers in aged care, disability care, Aboriginal health care and hospital care with no sick leave entitlements.

32 COVID-19 case isolation requirements remain in several countries, including Denmark, Ireland, the Netherlands, and Singapore.

Review of case isolation requirements

33 Officials have analysed several options for self-isolation for cases:

33.1. Option One: Retain the status quo of seven-day mandatory self-isolation (Director-General recommendation);

33.2. Option Two: A test-to-release policy, where the isolation period is decreased to five days with a negative RAT to release, or cases must isolate for a maximum of seven days, whichever comes first;

33.3. Option Three: Reduce the mandatory self-isolation period to five days; or

33.4. Option Four: Case isolation requirements are removed, and replaced with guidance.

Public health advice

34 The Director-General recommends the current requirement for all cases to isolate for seven days is retained.

35 It is considered likely New Zealand will experience a further wave by the end of 2022. The Director-General noted self-isolation for cases remains our most effective measure to reduce transmission of COVID-19. Best practice for managing infectious diseases transmitted through the droplet or airborne route is to require isolation of cases during their infectious period, which breaks the chain of transmission by preventing infectious people from having contact with and infecting others in the community. The high transmissibility of COVID-19 reinforces the need for case isolation, which has been key to the public health response throughout the pandemic.

36 Modelling undertaken by COVID-19 Modelling Aotearoa (CMA) suggests that the removal of case isolation would result in about 35,000-65,000 more cases, 280-470 more hospitalisations and 35-60 more deaths in the short-term (15-45 days after

implementation). This modelling also did not account for the impact of new variants, so likely underestimates the baseline number of cases, hospitalisations, and deaths. COVID-19 Modelling Aotearoa is now working on a variant model based on the estimated growth advantage of current variants.

37 We have reduced isolation requirements over the course of the pandemic, but seven days is likely the minimum threshold for self-isolation to remain an effective intervention. If the mandatory self-isolation period were reduced to five days, modelling suggests there would be an additional 150 hospitalisations and 20 deaths in the short-term, and an additional 380 hospitalisations and 117 deaths over the next year. With the addition of a test-to-release policy, reducing mandatory isolation from seven days to five days is likely to result in increased cases and hospitalisations. Cumulative cases are modelled to increase by 7.7 percent, from 63,000 to 68,000, and deaths by 5.2 percent from 115 to 121, from day 15 to day 45 after implementing the change[1]. Over the next year cases are expected to increase by 1.4 percent from 829,500 to 841,000, and deaths by 2.1 percent 1,864 to 1,904. Shifting from mandatory isolation to guidance is modelled to have significantly larger impacts on health outcomes, with cases and hospitalisations potentially increasing by 50 to 140 percent in the short term and 10 to 20 percent over the next year. A key limitation of this modelling is it assumes no new var Modelling is discussed in more detail at Appendix One of the attached Public Health Risk Assessment Memo (p. 26-31).

38 It is also important to see the available tools as a suite of protections that work together. With previous reviews of COVID-19 settings we have been able to remove or reduce other requirements because case isolation has remained in place. However, no combination of other measures is likely to produce the same public health benefit as required self-isolation.

39 s9(2)(g)(i) [redacted] In the United Kingdom, there was a significant drop in isolation after the legal requirement was removed on 24 February 2022[3].

s9(2)(g)(i) [redacted]

41 s9(2)(g)(i) [redacted] People in lower socio-economic groups are more likely to be exposed to COVID-19[4]. s9(2)(g)(i) [redacted]

[1] Scenario 2, p 28, Appendix 1 of the attached Public Health Risk Assessment Memo.
[2] Manatū Hauora commission regular qualitative surveys with the September one covering self-isolation.
[3] 80 percent were fully compliant in February, dropping to 64 percent in early March and 53 percent in late March (based on surveys conducted by the UK Office of National Statistics).
[4] For example, because they tend to work in jobs with greater risk of exposure, to live in larger and typically more crowded houses, and to have underlying risk factors.

s9(2)(g)(i) [redacted]

[redacted] The recent removal of the requirement does not appear to have significantly altered case and hospitalisation numbers. Based on this experience and the current outbreak context, daily testing for five days for household contacts continues to be considered a sufficient risk mitigation.

43 s9(2)(f)(iv) [redacted]

Population and sector impacts

44 Retaining seven-day case isolation is preferred to mitigate the impact on older people, people in lower socioeconomic groups, and the disabled community. s9(2)(g)(i) [redacted]

[redacted]

[redacted]

s9(2)(g)(i) [redacted]

48 If there is no case isolation requirement, MBIE advises that an employer or person conducting a business or undertaking (PCBU) under the Health and Safety at Work Act 2015 (HSWA) will need to rely on normal employment and health and safety law requirements. Where an employee is unwell, they should take paid or unpaid sick leave. An employer could have a policy that unwell workers may not come to work under a combination of employment and health and safety law requirements, so long as they have followed good faith consultation requirements and the policy is implemented reasonably. Some employers or PCBUs may also direct unwell workers not to attend a workplace. Employers and PCBUs need to consider the duties they have to all workers in a workplace, particularly managing the risk that someone who has COVID-19 would present to other workers. If self-isolation is no longer mandatory, then employers and PCBUs are likely to face more challenges in implementing policies in these areas and there will be some inconsistency in how employers and PCBUs choose to manage these risks.

49 s9(2)(g)(i) [redacted]

Economic impacts

51 The Treasury considers that retaining the current isolation requirements would have a small negative economic impact relative to no case isolation, which could compound existing labour pressures faced by businesses. However, as many people required to isolate now would otherwise be unwell and not working for much or all of the relevant

[5] Of the 45,173 people who current receive funded Disability Support Services through Whaikaha, 93 percent of funded disabled people over 18 years have been fully vaccinated. In comparison, only 52 percent of funded disabled people aged 5-18, and 29 percent of those aged 5-11, have been fully vaccinated.

period, the impact is likely small. The impact may be somewhat offset by cases increasing if isolation is removed, but this is difficult to assess with any certainty.

52 Based on modelling by COVID-19 Modelling Aotearoa, test-to-release (modelled with a five-days minimum, seven-days maximum) would only result in 6.2-8.8 percent more cases being released while infectious, but around one fewer day spent in isolation per case. s9(2)(g)(i) [redacted]

Support schemes

53 The existing isolation requirements are supported by two support programmes: the Leave Support Scheme (LSS) and the Care in the Community (CIC) welfare response. Both have a significant fiscal cost.

54 The cost of the LSS has reduced in line with the reduction in case numbers, with only $15 million paid out in September 2022 (compared to $180 million paid out in March 2022). The scheme has cost about $30 million per 100,000 cases in 2022.

55 s9(2)(g)(i) [redacted]

56 The Government has provided funding totalling $407.9m for the CIC response to provide welfare support to individuals and whānau impacted by COVID-19. Of this, $15.5m is contracted to the Ministry of Housing and Urban Development and MBIE. To date $213.1m has been committed primarily through the community connection service and Food Secure Communities Programme but other components have been funded to support delivery, including: regional assessment and referral, iwi partnership, provider capability, support for the disabled community, community awareness and preparedness, personal protective equipment, and evaluation.

57 In April 2022 Cabinet agreed to a transition plan which enabled CIC services to pivot flexibly between crisis response and supporting communities to recover from COVID-19 social impacts as case numbers fluctuated. This enabled the NGO embedded Community Connector support for those in self-isolation to also be made available to people who were impacted by COVID-19, including hard to reach individuals and whanau through trusted community providers. There are therefore two purposes for support:

57.1. Supporting safe self-isolation (food and Community Connector discretionary funding); and

57.2. COVID-19 impact and recovery support - used to support non-isolating households with short-term social supports (Food Secure Communities and Community Connector discretionary).

58 The Minister of Finance and the Minister of Social Development and Employment have proposed that further decisions regarding eligibility for CIC support and associated funding be delegated to them. s9(2)(g)(i) s9(2)(f)(iv)

Point-of-care testing

59 The importation, manufacture, supply, sale, packaging and use of point-of-care tests is regulated under the Point-of-care Tests Order. The purpose of this order is to ensure point-of-care tests relied on to establish whether a person is subject to mandatory self-isolation are accurate and reliable. s9(2)(f)(iv)

Review of mask requirements

60 The requirements for masks are set out in the Masks Order. The Masks Order specifies that masks are legally required for visitors in a wide range of healthcare services (including primary care, urgent care, pharmacies, hospitals, aged residential care, disability-related residential care, and allied health). There are exclusions for patients and people receiving residential care, health service staff, and visitors to specific health services (for example, psychotherapy, counselling, mental health and addiction services). Requirements for patients and workers are determined by the health service, based on local assessments in line with Infection Prevention and Control guidance.

61 There are two options for masks:

61.1. Option One: Revoke the Masks Order and provide guidance to health services to set mask policies for visitors as well as staff and patients; or

61.2. Option Two: Retain government mandated mask requirements for visitors to healthcare services (Director-General recommended).

Public health advice

62 The Director-General has recommended that the current mask requirements should be retained. It is now considered likely that there will be a further wave of COVID-19 in New Zealand this year, and there is substantial evidence that mask wearing significantly decreases the rate of transmission of COVID-19 and other airborne respiratory viruses[6].

[6] e.g., The Efficacy of Facemasks in the Prevention of COVID-19: A Systematic Review. Bedir Alihsan, Arrianna Mohammed, Yash Bisen, Janice Lester, Christian Nouryan, Joseph Cervia. medRxiv 2022. https://www.medrxiv.org/content/10.1101/2022.07.28.22278153v1

63 Health services have an elevated risk of transmission and/or the risk of severe disease because:

63.1. They are more likely to have people present with undifferentiated viral illness, either because they are seeking help for symptoms or because they have a co-existing medical emergency;

63.2. They are more likely to have vulnerable people present (either due to age, underlying conditions, or to being unwell at the time), so mask requirements ensure that people who are at higher risk can access health services without avoidable additional risk; and

63.3. They have variable ability to improve crowding, indoor ventilation, and air filtration.

64 s9(2)(g)(i) [redacted]

65 Mask requirements ensure people who are at higher risk of severe infection can access health services without avoidable additional risk. A conservative estimate is that one in every six New Zealanders is at higher risk of severe illness if they contract COVID-19.

66 Removing mask mandates in health service settings may lead to an increase in cases of hospital-acquired COVID-19. Hospital-acquired COVID-19 infections are more likely to have poorer outcomes than community-acquired COVID-19 infections, based on evidence from Victoria, Australia. Feedback from two districts has noted possible links between visitors and hospital-acquired COVID-19 infections. Therefore, there is still value in trying to prevent infections.

67 s9(2)(g)(i) [redacted]

s9(2)(g)(i)

[redacted]

Economic impacts

73 The Treasury does not consider that current mask requirements, or the proposed change are likely to have any measurable economic impact.

Provision of information by air arrivals for COVID-19 contact tracing

74 Air travellers coming into New Zealand are currently required under the Air Border Order to declare their contact details and travel history prior to arrival through the online NZTD for COVID-19 contact tracing purposes.

75 Wider functions for the NZTD will be in place in the future through amended Customs (Arriving Passenger and Crew Declaration) Rules (the Customs Rules), but the provision of information requirement in the Air Border Order (the current basis for the NZTD) needs to be justified by public health advice.

76 There are two options for the requirement for air arrivals to provide information for COVID-19 contact tracing:

76.1. Option One: Remove requirements for air arrivals to provide information for COVID-19 contact tracing purposes (Director-General recommended); or

76.2. Option Two: Retain the requirement for air arrivals to provide information for COVID-19 contact tracing purposes.

Public health advice

77 The Director-General recommends removing the requirement for air travellers to New Zealand to provide information using the NZTD for contact tracing purposes, as this is not considered proportionate in the current context.

78 From 5 November, amended Customs (Arriving Passenger and Crew Declaration) Rules (the Customs Rules) come into force, which will provide a legal authority to require passengers to complete the NZTD, absent a public health rationale. Continuing the requirement under the Air Border Order until the amended Customs Rules come into effect on 5 November means there will be a seamless transition and the ability to contact passengers in the intervening period will be retained. There are legal and privacy risks if the Air Border Order requirements continue beyond the expiry of the epidemic notice.

79 Having air traveller contact details and travel history electronically collected using the NZTD supports a more efficient and accurate dataset of passenger information, should contact tracing be required in the future. While the likelihood of needing to stand up contact tracing is considered low in the current context, the rate at which the COVID-19 virus continues to mutate means that we need to ensure our systems remain prepared. If required, passenger information could be accessed from Customs under provisions in the Health Act 1956 for contact tracing purposes.

Sector and population impacts

80 s9(2)(g)(i) [redacted]

Customs Rules

82 Customs, with the Ministry for Primary Industries, MBIE, the Ministry of Transport, the Ministry of Foreign Affairs and Trade and Manatū Hauora are working to modernise

border processes, including the ongoing development of the electronic NZTD to replace the current paper arrival card by June 2023.

83 As part of this work and to allow for continuing development and trialling of the NZTD, Customs is putting rules in place under section 421(1) of the Customs and Excise Act 2018 requiring travellers arriving in New Zealand by air to complete some existing questions from the Passenger Arrival Card digitally as well as on the arrival card. On 7 October 2022, the Customs Rules were gazetted. These will come into effect on 5 November 2022.

84 There will be a gap of about two weeks between the expiry of the epidemic notice on 20 October and when the Customs Rules come into effect for Customs' purposes on 5 November.

s9(2)(h) [redacted]

87 The Government's Chief Privacy Officer supports the removal of the contact tracing requirement. As a result of the changing COVID-19 circumstances, collecting personal information is now unnecessary and disproportionate. Continuing to collect it would breach Principle 1 of the Privacy Act 2020 which requires agencies only to collect personal information where that is necessary for a legitimate purpose.

88 From 5 November, the purpose for which the NZTD information is collected will change from contact tracing to Customs information. The information collection is substantially the same as is already collected on the paper arrival card, which pre-dated COVID-19. The change is in the mode of collection, which is shifting from the paper arrival card to the NZTD by June 2023.

89 Customs advise the NZTD will remain operational in a voluntary capacity during the two-week gap. People opting not to fill in the NZTD would not be able to use the eGates on arrival into New Zealand.

Post-arrival testing

90 Mandatory post-arrival testing was removed in September 2022 and replaced with guidance for air arrivals to test on days 0/1 and 5/6 and to follow up positive results with a PCR test to enable WGS to detect new variants [CAB-22-MIN-0380 refers].

91 There are two options for post-arrival testing:

91.1. Option One: Update guidance so that only symptomatic air arrivals are recommended to test, and encouraged to get a PCR if tested positive within a week of arrival (Director-General recommended); or

91.2. Option Two: Retain guidance for all air arrivals to test on days 0/1 and 5/6 followed with a PCR test if positive.

Public health advice

92 In September, the Director-General recommended mandatory post-arrival testing be replaced with guidance which should only apply to travellers who become symptomatic within a week after arrival. Cabinet asked that Manatū Hauora report back to the Minister for COVID-19 Response with an overview of how variant surveillance is being undertaken in the current context. This report back is expected shortly.

93 New variants are typically first detected overseas, so our primary source of information is through our international intelligence networks and data sources. Within New Zealand, surveillance for new variants is undertaken using Whole Genome Sequencing (WGS) of PCR test samples (at the border, in hospitals, and in the community) and through WGS of community wastewater.

94 The Director-General continues to recommend a more proportionate approach is for guidance to travellers to test if symptomatic and those who test positive within a week of arrival are encouraged to get a PCR test. Advising all air travellers to test (whether symptomatic or not) is not proportionate to the lower prevalence of COVID-19 globally, the relatively high imposition on travellers, s9(2)(g)(i) [redacted]

95 While post-arrival testing aims to provide additional early surveillance of new variants crossing the border, the one-to-two-week lag time from the point of arrival to a WGS result from a positive PCR test means testing at the border is unlikely to detect new variants arriving in the country before community spread occurs.

[7] s9(2)(g)(i), s9(2)(i) [redacted]

Consultation

96 This paper was prepared by the COVID-19 Group in the Department of the Prime Minister and Cabinet, with review and input by Manatū Hauora including advice on the course of the outbreak, the public health response, and the views and recommendations of the Director-General.

97 The following agencies were also consulted on the paper: New Zealand Customs Service, Crown Law Office, Department of Internal Affairs, Department of Corrections, Ministry of Business, Innovation, and Employment, Ministry for Culture and Heritage, Ministry of Education, Ministry for Ethnic Communities, Ministry of Foreign Affairs and Trade, Ministry of Housing and Urban Development, Ministry of Justice, Ministry for Pacific Peoples, Ministry for Primary Industries, Ministry of Social Development, Ministry of Transport, Oranga Tamariki, Parliamentary Counsel Office, Police, Public Service Commission, Te Aka Whai Ora, Te Arawhiti, Te Puni Kōkiri, Te Whatu Ora, the Treasury, Whaikaha – Ministry of Disabled People, Office for Seniors.

98 DPMC also carried out engagement based on draft public health advice with members of the National Iwi Chairs Forum (NICF), other iwi Māori leaders, and the Strategic Public Health Advisory Group.

99 s9(2)(g)(i) [redacted]

101 The Strategic Public Health Advisory Group discussed the limitations of using personal experience to understand compliance or the effectiveness of public health measures, and emphasised the importance of social science to understand and monitor community and sector attitudes. They also noted that their highest risk patients regularly visit pharmacies, so mask requirements should reflect that. Members also noted the value of considering COVID-19 in the context of other respiratory illnesses generally, rather than in isolation.

102 s9(2)(g)(i) [redacted]

Financial Implications

103 Financial implications have been included in relevant sections of this paper.

Legislative Implications

104 Removing requirements for air arrivals to provide contact tracing information for COVID-19 contact tracing requirements would require amending or revoking the Air Border Order.

105 If current settings for self-isolation and masks are recommended to be retained, there are no legislative implications for the Self-Isolation Order or the Masks Order.

106 If requirements for cases to self-isolate are removed, this would require amending or revoking the Self-Isolation Order. As a consequence, this would entail amending or revoking the Point-of-care Tests Order.

107 If mask requirements for visitors to healthcare settings are removed and replaced with guidance to health services to set mask policies for visitors, this would require amending or revoking the Masks Order.

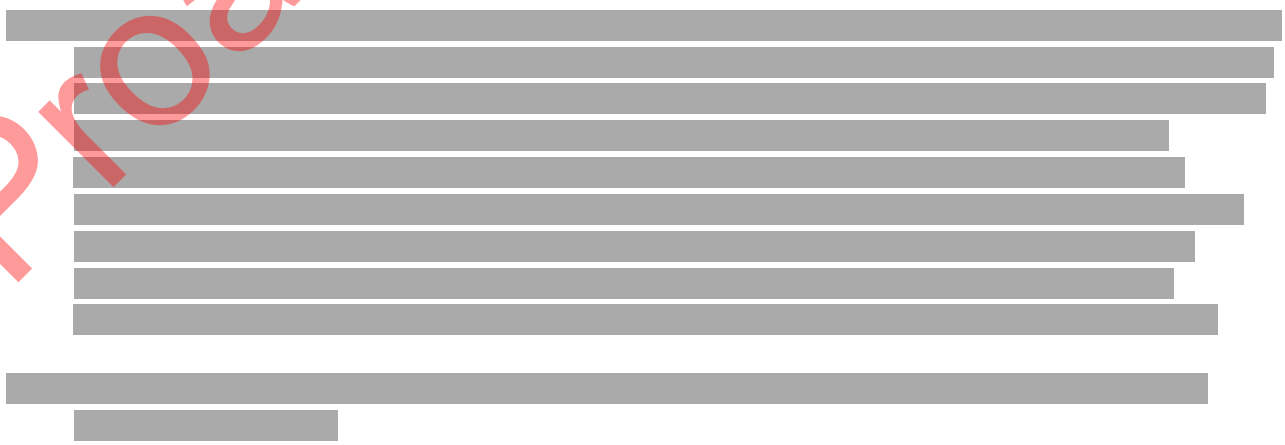
Impact Analysis

108 A quality assurance panel with members from the Department of the Prime Minister and Cabinet and Manatū Hauora has reviewed the Regulatory Impact Statement and considers it partially meets the quality assurance criteria. The analysis of the options is good, and the criteria used are appropriate. However, as the authors note, there has been limited consultation, and equity considerations are only lightly covered. To some extent this is mitigated by the public health risk assessment referred to, but equity should be more closely monitored in implementation.

Human Rights

109 It is proposed to retain the current 7-day isolation period for positive cases (with guidance for household contacts to test daily for 5 days) and retain face mask requirements for visitors on the premises of health services.

s9(2)(h)



s9(2)(h)

[redacted]

Population Implications

116 I have previously advised of the potential population implications of the change to the approach for COVID-19, including targeted protections for the most vulnerable as some people are at higher risk of adverse outcomes from the virus. The burden of COVID-19 does not fall equally, and some people are at higher risk of adverse health outcomes from the virus. As the COVID-19 risks decrease, the negative cultural, social and economic impacts of restrictive measures are less justified. However, whatever the settings of measures, COVID-19 could disproportionately affect

populations groups such as older people, disabled people, Māori, Pacific peoples, and some ethnic communities.

117 As at 9 October 2022, 2,055 deaths have been attributed to COVID-19 out of about 1.7 million reported cases. Most of this burden has fallen on older people. The disease burden has also fallen disproportionately on Māori and Pacific communities, and those with prior conditions including disabilities, and those in low socio-economic conditions, among others. The *COVID-19 Mortality in Aotearoa New Zealand: Inequities in Risk* report released by Manatū Hauora in September 2022 highlights the disparity of the pandemic. Overall mortality has continued to decline, however after adjusting for age, comorbidities and vaccination status, the report showed that the risk of COVID-19 mortality in Māori is 2.2 times higher than that of European and Other group, while for Pacific Peoples the risk was 2.8 times higher.[8]

118 The overall population rate for hospitalisations is 0.6 per 100,000 (as at 18 September 2022). Older people have substantially higher hospitalisation rates and, within each age group, Māori and Pacific peoples also have higher hospitalisation rates.

119 While cases and hospitalisations continue to trend downwards overall, public health advice notes that there is not currently focussed modelling on how removing self-isolation and mask requirements would impact Māori, tāngata whaikaha Māori and disabled people. Currently modelling on potential policy changes forecasts impacts such as case numbers, hospitalisations and mortality for the general population, but does not provide this information for vulnerable groups. A precautionary approach will help to clarify the impact of changes on the most vulnerable people in New Zealand and help ensure that Te Tiriti obligations are met, supported by the development of modelling to specifically assess equity impacts.

120 Any changes to requirements need to be clearly explained with messages tailored to different mediums and audiences, particularly vulnerable communities. As masks are still an effective tool for reducing the spread of COVID-19 and other respiratory illnesses, these will still be supplied for free when picking up RATs and in many other sites, allowing for ongoing voluntary mask use.

Older people

121 Older people experience the impacts of any COVID-19 resurgence disproportionately, both due to clinical vulnerability and social factors. If there are changes to requirements for testing including 5-day isolation and test to release, and requirement to tests will need to be clearly communicated, with communications in an accessible format with print or other options. Some older people have opted to voluntarily self-isolate due to confusion about government requirements, or perception of risk.

122 The impacts of any COVID-19 resurgence will fall disproportionately on older people – both due to clinical vulnerability and social factors. Increases in COVID-19 numbers are likely to lead to fear and potential “voluntary self-isolation” among some older people who are or perceive themselves to be at risk.

[8] Ministry of Health. 2022. COVID-19 Mortality in Aotearoa New Zealand: Inequities in Risk. Wellington: Ministry of Health

123 There have been considerable impacts of previous outbreaks on aged residential care facilities, and changes to self-isolation could impact the inherent vulnerability of residents, supporting retention of the status quo for self-isolation and masking requirements.

Disabled people and tāngata whaikaha Māori

124 Disabled people, including tāngata whaikaha Māori, and those with underlying medical conditions are more likely to be hospitalised or require medical intervention or support if they test positive for COVID-19. Removing measures, or making changes to self-isolation requirements that are not expected to affect the burden on the health system overall, may result in the burden being transferred to and disproportionately experienced by disabled people and some ethnic communities and their whānau.

125 The Human Rights Commission's report 'Inquiry into the Support of Disabled People and Whanau During Omicron' found that lessening restrictions led some disabled people to choose to isolate themselves, leading to feelings of isolation and stress and a restriction on their own freedoms for the benefits of others. The continuation of measures, particularly face masks when accessing essential services, creates reassurance. s9(2)(g)(i)

127 Sector representatives reinforced the importance of tailored service provision and communications for the diverse disability sector each time there is a change in guidance or requirements. Some disability sector representatives continued to express concerns about the lack of general understanding on what it means to be vulnerable in New Zealand.

128 Disabled people have higher unmet healthcare needs (GPs, primary healthcare, and dental healthcare) compared to non-disabled people (NZ Health Survey, 2020/21). s9(2)(g)(i)

s9(2)(g)(i) [redacted]

Māori

129 The COVID-19 outbreak has had a disproportionate impact on Māori, and worsened the already inequitable health outcomes for Māori. Māori at are a higher risk of COVID-19 infection, hospitalisations and death due to inequitable vaccination rates, pre-existing health conditions and other structural factors (e.g. housing deprivation).

130 Related response measures are expected to continue to have a positive impact for Māori, including the ongoing mandatory measures. s9(2)(g)(i) [redacted]

132 As I have previously noted, we have some well-established baseline measures in place, including high vaccination rates, however there is more work to be done in encouraging booster vaccination uptake among Māori as Māori vaccination rates are lower. The Karawhiua campaign, led by the Iwi Communications Collective and Te Puni Kōkiri was re-launched on 5 October 2022 with the aim to boost vaccination rates for Māori. Retention of measures including self-isolation and masking requirements allows further time to increase vaccination rates for Māori.

133 NICF members and disability sector representatives have continued to reinforce the value of Kaupapa Māori providers in reducing inequities as they provided holistic support for whānau and had deeper reach than other providers. Te Aka Whai Ora reported that Māori providers support the retention of the COVID-19 workforce, or re-deployment to roles which more holistically address oranga whanau, or an all of health approach that includes both health and social services within Māori communities.

Pacific peoples

134 Pacific peoples continue to be disproportionately affected by COVID-19 and continue to experience long-standing inequitable health outcomes and service use. Recent data shows proportionately Pacific peoples are most hospitalised for COVID-19 and their COVID-19 mortality rate is greater than European or other ethnicities (when accounting for differences in age profiles). Based on this, and the ongoing risk posed to vulnerable communities, the status quo for both case isolation and mask requirements is preferred.

Other groups

135 Transitioning from mandatory isolation to testing requirements or guidance will be more challenging for prisons to implement, as prison units are treated as households for the purpose of these requirements.

Te Tiriti o Waitangi analysis

136 The Crown's obligations to Māori under Te Tiriti o Waitangi require active protection of taonga and a commitment to partnership that includes good faith engagement with and appropriate knowledge of the views of iwi and Māori communities.

137 Data and engagement continues to highlight that the current outbreak has had a disproportionate impact on Māori. Māori are at higher risk of COVID-19 infection, hospitalisation, and death due to inequitable vaccination rates, incidence of pre-existing health conditions, and structural factors (e.g., housing deprivation). Māori may also suffer long COVID for longer than non-Māori, with one study showing that 75% of Māori participants had long COVID for more than three months, compared to only 65% of non-Māori.[9] Although there is recognition that the ongoing use of rights-limiting measures presents challenges, the measures have a positive impact on the Crown's ongoing obligation to protect Māori health outcomes. These responsibilities are reiterated in Te Pae Tata, the New Zealand Health Plan.

138 NICF and Te Aka Whai Ora also raised an ongoing need for Māori-led research into the impacts of COVID-19 on Māori. As part of a package of funding to research the ongoing impacts of COVID-19, and inform future pandemic responses, Te Whatu Ora – Nelson Marlborough and Te Kotahi o te Tauihu Charitable Trust have launched Te Tauihu COVID-19 Research Project. The project focuses on Māori living in the top of the South Island, interviewing people who have experienced COVID-19 or have been impacted in some way.

Next steps and publicity

139 s9(2)(f)(iv)

140 The Minister for COVID-19 Response will announce Cabinet's decisions on this paper during the week of 17 October.

141 If changes to self-isolation are agreed and intended to be in place within 48 hours of announcement, this will have significant operational implications for MSD and other agencies.

Proactive release

142 This paper will be proactively released following Cabinet consideration.

[9] Ministry of Health. 2022. Long COVID Evidence Update - 11 August 2022. Wellington: Ministry of Health. 16.

Recommendations

The Minister for COVID-19 Response recommends that Cabinet:

1. note that in September 2022, because of the declining COVID-19 risk, we moved to a new more stable approach to managing the virus, based on baseline and reserve measures [CAB-22-MIN-0380];

2. note that in September 2022, Cabinet agreed to [CAB-22-MIN-0380]:

   2.1. remove COVID-19 border vaccination requirements, post-arrival COVID-19 testing requirements (replaced with guidance for air arrivals to test on days 0/1 and 5/6), and requirements not to exhibit COVID-19 symptoms or be under a public health direction for arrivals;

   2.2. remove all remaining COVID-19 vaccination mandates;

   2.3. remove mandatory self-isolation of household contacts, to be replaced with guidance only to test daily for five-days;

   2.4. retain mandatory self-isolation of cases for seven days;

   2.5. retain requirements for air travellers to provide information for COVID-19 contact tracing purposes prior to departure; and

   2.6. retain government mandated masks for visitors to healthcare services, including primary care, urgent care, hospitals, aged residential care and disability-related residential care but excluding counselling, mental health and addiction services;

3. note that the Director-General of Health has provided advice to the Prime Minister and other relevant Ministers on the renewal of the Epidemic Preparedness (COVID-19) Notice 2022 (the epidemic notice) and recommended letting it expire at 12:01am on 20 October 2022;

4. s9(2)(h) [redacted]

Review of case isolation requirements

5. agree, for self-isolation of cases:

   EITHER

   5.1. on the basis that the legal basis has been confirmed, to retain the status quo of seven-day mandatory self-isolation (Director-General of Health recommended);

   OR

   5.2. to remove self-isolation requirements;

6. note that the Director-General of Health recommended retaining the current guidance for household contacts to test daily for five days;

Review of government mandated mask requirements

7. agree, for masks:

   EITHER

   7.1. to remove the mask requirement and provide guidance to health services to set mask policies for visitors as well as staff and patients, which they have been responsible for throughout the pandemic;

   OR

   7.2. on the basis that the legal basis has been confirmed, to retain government mandated mask requirements for visitors to healthcare services (Director-General of Health recommended);

Provision of information for contact tracing for air arrivals

8. note that the New Zealand Traveller Declaration (NZTD) for Customs purposes will be enabled by rules under section 421(1) of the Customs and Excise Act 2018 (the Customs Rules) from 5 November 2022, and passenger contact information could be accessed under the Privacy Act 2020 and/or the Health Act 1956 if needed for contact tracing purposes;

9. agree to remove requirements for air arrivals to provide contact information for COVID-19 contact tracing purposes from the COVID-19 Public Health Response (Air Border) Order 2021 (the Air Border Order) (Director-General of Health recommended);

10. note the NZTD will remain operational in a voluntary capacity during the two-week gap between the removal of the requirements from the Air Border Order and the Customs Rules coming into effect, and people opting not to fill in the NZTD would not be able to use the eGates on arrival into New Zealand;

Post-arrival testing

11. agree, for post-arrival testing to update guidance so that only symptomatic air arrivals are recommended to test, and if positive within a week of arrival to get a PCR test (Director-General of Health recommended);

12. note that, in the event of a variant of concern with high clinical severity and high immune evasion, the disruption caused by COVID-19 may justify an epidemic notice, enabling the use of COVID-19 orders and emergency powers under other legislation;

s9(2)(f)(iv) [redacted]

Support schemes

14. s9(2)(g)(i) [redacted]

15. agree that further decisions regarding eligibility for CIC support and associated funding be delegated to the Minister of Finance and the Minister of Social Development and Employment;

Next steps

16. note that, to give effect to the above decisions, the Minister for COVID-19 Response will revoke or retain:

    16.1. the COVID-19 Public Health Response (Air Border) Order 2021;

    16.2.the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022;

    16.3. the COVID-19 Public Health Response (Masks) Order 2022; and

    16.4. the COVID-19 Public Health Response (Point-of-care Tests) Order 2021;

17. note that any remaining government mandated measures will be reviewed in late November 2022;

18. s9(2)(f)(iv) [redacted]

Authorised for lodgement

Hon Dr Ayesha Verrall
Minister for COVID-19 Response

Appendix One: Public Health Risk Assessment of COVID-19 mandated response measures, 12 October 2022

Memo

Public Health Risk Assessment of COVID-19 mandated response measures, 3 October 2022

Date:	12 October 2022
To:	Dr Diana Sarfati, Director-General of Health
From:	Dr Nicholas Jones, Director of Public Health, Public Health Agency Dr Andrew Old, Deputy Director-General, Public Health Agency
For your:	Decision

Purpose of report

1. This memo provides you advice from the Director of Public Health following the 03 October 2022 Public Health Risk Assessment (PHRA). The PHRA considered whether the remaining mandated (and other) COVID-19 response measures are proportionate to the risk posed by the current outbreak.
2. This paper seeks your agreement to the recommendations arising from that meeting. The agreed recommendations will inform a paper on the future management of COVID-19 that the Minister for COVID-19 Response will take to Cabinet on 17 October 2022.

High level summary of key considerations

Previous PHRA recommendations

3. Advice provided to you following the 17 August 2022 PHRA recommended the removal of several mandatory measures based on public health advice that they were no longer proportionate and/or justified. Subsequently, requirements to wear masks in settings other than healthcare, and quarantine requirements for household contacts were removed, along with testing requirements for international arrivals.
4. Their removal was considered an appropriate response given New Zealand's COVID-19 outbreak at that time was waning, with reducing case numbers, hospitalisations, and deaths. The proportionality of many mandated response measures significantly reduced due to the changing context of the outbreak at that time.
5. It was agreed the remaining measures – the retention of case isolation, face masks in healthcare settings and electronic provision of contact details – would be kept under review and assessed again at the next PHRA. This stepped approach was considered a judicious way to manage the transition from mandatory measures. It also provided the opportunity to assess the impacts of these changes across key indicators to determine if it was appropriate to remove the mandates underpinning two of the four key pillars – masking, separation, vaccination and isolation – to our COVID-19 response.

Outcome of 3 October 2022 PHRA

6. Given the current domestic and international context, the PHRA recommendations represent a continuation of current measures, with some minor modifications. This assessment builds on evidence and recommendations from previous assessments (including the 17 August PHRA, and the CPF Assessments that preceded it).

7. Key to our ongoing precautionary approach is the need to protect vulnerable populations and reduce inequities.[1] COVID-19 morbidity and mortality data continue to highlight the disproportionate risks to Māori, Pacific, socio-economically disadvantaged and disabled communities.

8. Concerns were expressed that lifting mandates for case isolation and masking in healthcare facilities, could result in disproportionate impact on these groups. Requiring cases to isolate remains our most effective measure to reduce transmission of COVID-19, retaining case isolation will materially reduce transmission. Its retention also allows for the management of the response while removing or reducing other measures.

9. Modelling estimated that removal of case isolation, in addition to the changes made for face masking and household contact quarantine on the 12th of September would result in approximately 35-65,000 additional cases, 280-470 new hospitalisations and 35-60 additional deaths, in the short-term depending on 'optimistic' or 'pessimistic' modelling assumptions. The model did not account for the impact of new variants. These measures are therefore recommended to be retained.

10. Five days isolation with test to release is not recommended. Whilst less time in isolation is undeniably beneficial, this needs to be carefully balanced against the multi-faceted public messaging associated with introducing a negative test to release requirement, the potential increase in cases infectious at release, expectations around compliance and the recording of test to release results.

11. Further changes to border requirements: the removal of the requirement to provide contact details for contact tracing purposes[2]; and modifications to testing guidance for new arrivals were also considered.

    a. As contact tracing is not currently a feature of the COVID-19 response, the requirement to collect information for contact tracing purposes is no longer required. If the response changes, for example in response to a new variant, then contact tracing information may be sought again. The current requirement for collection via NZTD can be removed.

    b. The request to test on arrival currently applies for all passengers. The recommendation is this is modified to apply specifically to passengers who either arrive with, or develop symptoms, during their stay.

Outbreak status

Domestically, at the time of the PHRA, the current outbreak appeared to have stabilised

[1] Ministry of Health. 2022. COVID-19 Mortality in Aotearoa New Zealand: Inequities in Risk. Retrieved from https://www.health.govt.nz/publication/covid-19-mortality-aotearoa-new-zealand-inequities-risk

[2] Currently via the New Zealand Traveller Declaration (NZTD).

12. The PHRA considered data to the week ending 25 September 2022, which showed all measures used to monitor the COVID-19 epidemic as stable or reducing.

13. However, as of the week ending 7 October 2022, case counts have started to increase slightly in the context of likely lower reporting/testing and overall lower case ascertainment (although other key measures, including hospitalisations and deaths, remain stable):

    a. there is currently an average of 1,598 new reported[1] cases per day nationally (7-day rolling average to 9 October 2022); this was a 12 percent increase on the previous week

    b. the 7-day rolling average of reported case rates was 32.2 per 100,000 population for the week ending 9 October; this was 11 percent higher than the previous week, which was 28.6 per 100,000

    c. hospital occupancy trends from COVID-19 have stabilised in the week ending 09 October and levels of viral particles in wastewater have been relatively constant in the recent weeks to 02 October. The trend varied somewhat regionally, with some regions experiencing increases and some decreases.

14. Note that a Ministry of Health COVID-19 hospitalisation data review has identified a coding error which has resulted in potentially a significant number of COVID hospitalisations not being captured in the official count. The coding team are working through the issue. However, the technical issue appears to affect hospitalisations uniformly over time and appears not to impact trends in the data. Therefore, it is unlikely that the data error has impacted current recommendations, as the error is in miscounts distributed across the entire outbreak period from 2020 to present day and does not indicate a substantial change in the current risk profile. This error did not impact the daily/weekly reporting of number in hospital.

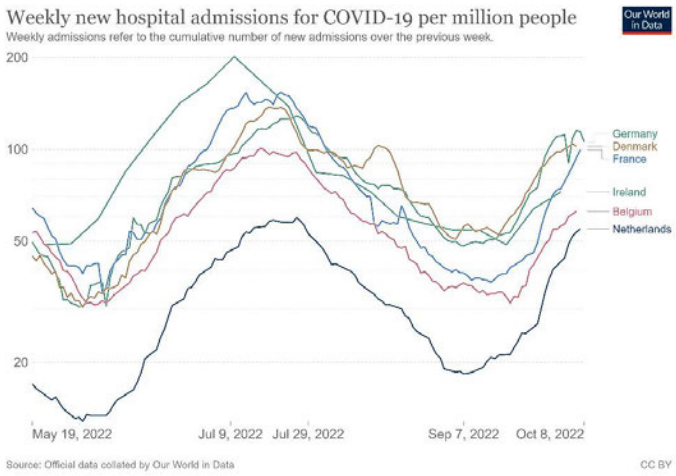
Following new data and intelligence over the past week, it is likely that New Zealand will experience a further wave by the end of 2022

15. Modelling developed for and discussed at the PHRA, showed a slow rise through the end of the year. However, this modelling was based on immune waning alone and not on the arrival of new variants.

16. It is likely that New Zealand will experience an increase in cases by the end of 2022, either due to waning, new subvariants, and/or behaviour change. However, data is very preliminary and as such the impact on cases, hospitalisations and deaths is unknown.

17. As indicated by Figure 1 below, hospitalisations are rising in many counties in Europe.

Figure 1: Weekly new hospital admissions for COVID-19 per million people (log scale)



18. The data from the UK suggests that, at this time, this is due primarily to seasonality factors (eg, returns to indoor settings, school/office) and immune waning (eg, due to time since previous Omicron wave and boosting).[3] Subvariants are not currently thought to be the primary driver of the increase in hospitalisations and cases in Europe, due to the prevalence of these new variants being too low at this time.

19. However, the collection of new subvariants is expected to be associated with an increase in cases in the future. The impact of the new variants on hospitalisations is unknown. It would be expected that booster vaccinations against the new subvariants would still maintain substantial protection against severe disease and hospitalisation, but no vaccine effectiveness data is available that is specific to these new subvariants.

There are a number of subvariants circulating domestically and internationally that appear to have a growth advantage over our predominant variant - BA.5

20. The data on subvariants is very uncertain and preliminary. However, bodies such as UKHSA report with low confidence that new subvariants have a growth advantage and may cause an increase in cases. Subvariant BA.2.75 appears to show initial signs of increasing in prevalence across New Zealand in both WGS and wastewater, and we have detected our first case of BQ1.1 in the last few days. It is unknown what impact the new variants will have on cases, hospitalisations and deaths.

21. Several subvariants may have a growth advantage over the current predominant variant, BA.5. However, generally a growth advantage of approximately 10 percent or more per day is thought to be required to be associated with a variant-driven wave of cases. Data are very preliminary, but it is thought based on European data that the growth advantage of at least one of the new subvariants (BQ.1.1) is between 10-15 percent. If this is correct, we would expect to see a rapid increase in the case numbers, sufficient to cause a wave.

    a. BQ1.1 is a sub lineage of BA.5 with additional mutations that likely make it more immune evasive.

    b. Similarly, BA.2.75.2 is a sub lineage of BA.2 with immune evasion potential. It is likely that the immune evasion properties are responsible for the growth advantage.

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1109820/Technical-Briefing-46.pdf

However, it is unknown if there will be an increase in hospitalisations or cases due to BQ.1.1 or any of the new variants, as this has not been observed in international data to date; only that the growth rate relative to other variants is elevated.

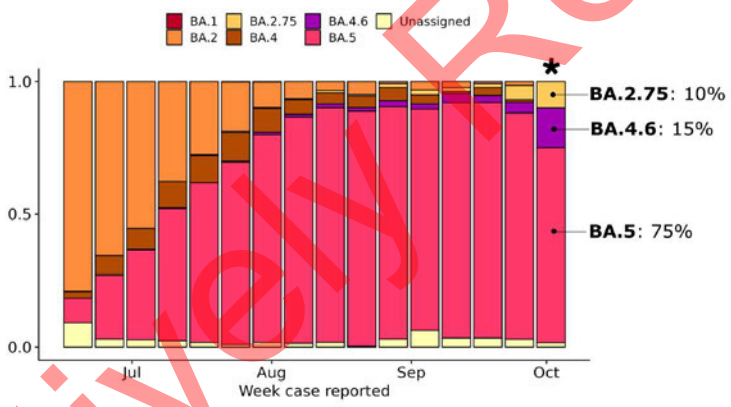
Subvariants such as BA.4.6 and BA.2.75 increased in the community in the most recent data from New Zealand samples that have undergone whole genome sequencing (WGS)

22. The most recent data from samples that have undergone WGS has found:
    a. BA.5. the dominant variant, accounts for ~75 percent of community individual WGS cases, in the week 17-30 September with BA.4.6 comprising an additional 15 percent.
    b. Therefore BA.4 and 5 account for about ~90 percent of cases.
    c. BA.2.75 has increased and accounts for ~10 percent.
23. Of note since the PHRA, the Institute of Environmental Science and Research (ESR) have now reported the first detection of BQ1.1 in New Zealand.

New Zealand wastewater testing indicates an increasing proportion of samples are not BA.5

24. As indicated by Figure 2 below, there has been a recent increase in the proportion of wastewater samples that are (sub)variants other than BA.5.

Figure 2: Frequency of variants/lineages in the past 16 weeks[4]



25. In summary:
    a. Wastewater testing (WWT) estimates of the prevalence of BA.4/5 agrees with that of individual WGS; BA.4/5 accounts for 90 percent of viral material in the WW (as of 02 October), which gives more confidence that the combined underlying prevalence of BA.5 and BA.4 in the community is likely truly ~90 percent, and is decreasing.
    b. WWT is unable to distinguish between BA.4 and BA.5, and therefore cannot identify increases in prevalence of BA.4.6 specifically.
    c. WWT also agrees that there is an increase in BA.2.75; BA.2.75, accounting for ~7 percent of viral material in the WW, which aligns with the 10 percent from individual

[4] Frequencies >1% are annotated in the last week. Note, data for the most recent fortnight is preliminary as it will be updated as cases reported within these weeks are converted into genomes. Data from the week marked with an asterisk represents all sequenced cases, before this reporting week border-related cases are excluded. Cases classified as Omicron (Unassigned) are typically partial genomes where it is difficult to be definitive regarding variant/lineage. Source: COVID-19 Genomics Insights (CGI) Report #24, 6 October 2022. https://www.esr.cri.nz/our-expertise/covid-19-response/covid19-insights/genomics-insights/

WGS. This indicates that BA.2.75 may be increasing in prevalence in the community. Monitoring of BA.2.75 includes the monitoring of sublineage BA.2.75.2.

d. BQ.1 has now been detected in New Zealand and would be expected to have a growth advantage based on overseas experience.

26. WWT for variants is not influenced by the changes in the individual WGS testing patterns.

Recommendations

27. It is recommended that you agree to the following:

Air travel to New Zealand	1. **Remove** the requirement for air travellers to New Zealand to provide information for COVID-19 contact tracing purposes prior to departure.	Yes
	2. **Note** that the Customs (Arriving Passenger and Crew Declarations) Amendment Rules 2022 will come into force on 5 November 2022 requiring air travellers to provide digital contact and travel history information that can be shared with Health agencies for contact tracing purposes as necessary under the Health Act 1956.	Noted
Post-arrival testing	3. **Modify** the post-arrival testing guidance for all travellers to test if symptomatic only.	Yes
Isolation and quarantine	4. **Retain** the current requirement for all cases to isolate for 7 days	Yes
Household contacts	5. **Continue** with guidance for all household contacts to test daily for five days, and if symptomatic beyond those five days.	Yes
Face masks	6. **Retain** the current face mask requirements for visitors[1] on the premises of health services, including aged and disability-related residential care and disability support services.	Yes
Further work to improve equity outcomes	7. **Agree** that the variants of concern preparedness work programme include measures to improve equity outcomes for Māori, Pacific, and disabled communities.	Yes
Next PHRA	8. **Agree** any remaining requirements are reviewed at the next PHRA.	Yes

	9. **Agree** that a further PHRA will be held in the last week of November to again review remaining mandatory measures.	Yes
Next steps	10. **Agree** to forward this memo to the Department of the Prime Minister and Cabinet (DPMC) to contribute to the paper for Cabinet on 17 October 2022.	Yes
	11. **Note** that once you approve this memo, we will provide it to Te Whatu Ora, Te Aka Whai Ora, and Whaikaha and suggest they provide any feedback to DPMC to reflect in the Cabinet paper noted above.	Noted
	12. **Note** that the advice contained in this memo may inform work to change COVID-19 policy settings, such as the amendment or revocation of COVID-19 orders.	Noted

Detailed discussion of the recommendations

Case isolation and requirements for household contacts

Current requirement	Mandatory 7-day self-isolation of COVID-19 cases
Director Public Health recommendation	**Retain** the current requirement for all cases to isolate for 7 days.
Public health rationale	*Requirements for case isolation and associated supports remain critical* Case isolation remains a cornerstone of our response to limiting transmission COVID-19 within the community. Isolation of cases can break the chain of transmission by preventing infectious people from having contact with, and infecting others within the community. Without required case isolation and associated supports, it is highly likely that adherence to guidance to isolate would be lower, leading to more infectious cases in the community, leading to increased community cases. *Removing case isolation and associated supports is likely to increase health inequities* It is likely that the increase in community cases would affect some communities and population groups more than others. Specifically: • There is an acknowledged differential exposure to COVID-19 risk related to socioeconomic status.[5] People in lower socioeconomic groups are more likely to work in jobs with greater risk of exposure, to live in larger

[5] Beale S, Braithwaite I, Navaratnam AM Virus Watch Collaborative, *et al*
Deprivation and exposure to public activities during the COVID-19 pandemic in England and Wales *J Epidemiol Community Health* 2022;**76:**319-326.

and typically more crowded houses, and to have underlying risk factors. If there are more infectious people circulating in a community with more baseline contacts, this increases the likelihood of onward transmission.

- People who are socioeconomically deprived are more likely to face challenges in being able to isolate compared to people with greater access to socioeconomic benefits. This includes differing access to sick leave, income loss, and potential pressure from employers to return to work. Earlier return to work comes at the cost of increasing transmission, which is likely a more significant effect on health outcomes and ability to work due to illness.
- As a result, people who experience higher levels of socioeconomic deprivation may be more likely to not test, not report results, or break isolation, potentially causing further cases and further inequities.
- These inequities would likely be exacerbated, rather than mitigated, if requirements for self-isolation and associated supports (such as Care in the Community and the Leave Support Scheme) – which are vital for enabling people in these communities to practically be able to isolate - were removed.

Feedback from sector stakeholders echoed many of the concerns above:

- s9(2)(g)(i) [redacted]
- Coercion to return to work particularly for the most vulnerable - Strong concern was expressed that if the isolation mandate was removed, employees may be pressured to return to work even if not fully recovered. Equity concerns were central to this feedback, particularly what this change might mean for Māori and Pacific communities.
- Increased transmission because of relaxed requirements - Removing the isolation mandate will almost certainly result in increased transmission, due in part to the message it sends regarding the importance of isolation and because of the inability of people to isolate due to the two factors above. Again, equity concerns were raised as any increase in cases will impact the priority populations most.

COVID-19 continues to pose a substantial public health risk, which is different from other respiratory and communicable diseases

- Disease burden: To date, 2,055 deaths have been attributed to COVID-19 (9 October) out of approximately 1.7 million reported cases. Most of this burden has fallen on the elderly. The disease burden also falls disproportionately on Māori and Pacific communities, and those with prior conditions including disabilities, and those in low socio-economic conditions, among other groups. With respect to hospitalisation, the overall population rate is 0.6 per 100,000 (18 September). Older people have substantially higher hospitalisation rates and, within each age group, Māori and Pacific communities also have higher hospitalisation rates.

- Post-infection sequelae: This includes long COVID, and increased risk factors for a range of other conditions (for example, cardiovascular disease,[6] neurologic and psychiatric disorders,[7] changes in brain structure,[8] and diabetes).[9] The data on long COVID is developing but there are still many unknowns and we need to continue to monitor the risk.
- The best way to reduce overall burden and protect vulnerable communities is via a combination of targeted measures (eg, additional precautions in Aged Residential Care facilities) and reduction of overall transmission in the community. Isolation and quarantine measures are among the most effective public health tools at reducing overall levels of community transmission.

A legal requirement to self-isolate is a cornerstone of the public health response

The best practice approach to managing infectious notifiable diseases transmitted through the droplet or airborne route is to require isolation of cases during their period of infectivity. This is the most effective tool for controlling disease transmission. The high transmissibility of COVID-19 reinforces the need for case isolation, which has been a cornerstone of the public health response throughout the pandemic.

s9(2)(g)(i) [redacted]

Other control tools, such as requiring masks or physical distancing are significantly less effective than isolation. Furthermore we note that to be effective these tools are most effective when utilized across the entire population. We note also that it is important to see these tools as a suite of protections that work together. Each tool can be dialled up or down. We have been able to recommend removing or reducing some of those other tools in part because isolation has remained in place. However, there is no combination of other mechanisms that would come close to producing the public health benefit that required self-isolation does.

s9(2)(g)(i) [redacted]

[6] Xie, Y., Xu, E., Bowe, B. *et al.* Long-term cardiovascular outcomes of COVID-19. *Nat Med* **28**, 583–590 (2022). https://doi.org/10.1038/s41591-022-01689-3

[7] Wise J. Covid-19: Increased risk of some neurological and psychiatric disorders remains two years after infection, study finds BMJ 2022; 378 :o2048 doi:10.1136/bmj.o2048

[8] Douaud, G., Lee, S., Alfaro-Almagro, F. *et al.* SARS-CoV-2 is associated with changes in brain structure in UK Biobank. *Nature* **604**, 697–707 (2022). https://doi.org/10.1038/s41586-022-04569-5

[9] Xie, Y. & Al-Aly, Z. *Lancet Diabetes Endocrinol.* https://doi.org/10.1016/S2213-8587(22)00044-4 (2022).

[10] The Research Agency (TRA). *July 2022 DPMC Behaviour & Sentiment Topline.*

s9(2)(g)(i) [redacted]

It is very clear that compliance will be significantly higher with a mandate than with a recommendation

Evidence from overseas suggests that a legal requirement to isolate will have significantly greater adherence than a recommendation to isolate. In the UK, there was a significant drop in compliance with isolation requirements after the legal requirement to self-isolate was dropped on 24 February 2022. Based on survey data of people who tested positive for COVID-19, 80 percent were fully compliant in February, dropping to 64 percent in early March, and 53 percent in late March.[11]

s9(2)(g)(i) [redacted]

Modelling results (CMA)

Modelling suggest that the current mandatory isolation policy is approximately preventing 450 hospitalisations and 50 deaths in the short term compared to guidance with a reduction to 5 days. Over a year, it is estimated to prevent 1000 hospitalisations and 300 deaths.

When current settings are compared to mandatory with test to release from 5 days, the model estimates that current settings are preventing 40 hospitalisations and 50 deaths in the short term. Over a year, it is estimated to prevent 250 hospitalisations and 30 deaths.

Accurate domestic data on the behavioural impact of shifting from mandatory isolation to guidance is lacking. However, data from the UK infection survey (based on adherence rates to guidance in the UK) suggests potentially larger increases in cases and hospitalisations from such a change.

Key limitations of the isolation model are that it assumes RAT sensitivity to be constant over the duration of illness and does not account for increased sensitivity at day 5. This means that the proportion of cases released who are infectious may be overestimated. Another limitation is that incomplete isolation under mandatory requirements is not fully accounted for. Both of these limitations would tend to overestimate the magnitude of increase associated with changes to the status quo. Furthermore the modelling does not account for a new variants which could substantially increase infections.

Modelling results are described in more detail in **Appendix 1**.

[11] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandselfisolationaftertestingpositiveinengland/17to26march2022

	It was noted that further change, such as the introduction 5-day self-isolation plus test to release, is likely to create additional uncertainty and confusion. People are more likely to adhere if isolation is mandatory. However, we have no accurate estimate of the proportion of people following the mandatory required. Behavioural data indicate 88% of those surveyed (July 2022) would follow isolation rules if they tested positive. Operational providers have reported that they believe the most critical factor is not whether isolation is mandatory or recommended, but rather whether people are adequately supported to do so.
Other comments	s9(2)(g)(i)  *Regulation of point of care testing* Currently, the importation, manufacture, supply, sale, packaging or use of point of care tests is regulated under the COVID-19 Public Health Response (Point-of-care Tests) Order 2021. The purpose of this regulation is to ensure that point of care tests that are relied upon to establish whether a person is subject to mandatory self-isolation requirements are accurate and reliable. It is appropriate to maintain the regulation of point of care testing, so long as mandatory self-isolation requirements remain in place.

	Other countries that have retained some level of required isolation for cases • Legally mandated isolation for a subset of higher-risk workers: Australia (from 14 October 2022). • Legally mandated isolation with test to release from 5 days: Germany.[12]

Guidance for household contacts of COVID-19 cases

Current requirement	All household contacts of COVID-19 cases are recommended to test daily for five days.
Director Public Health recommendation	**Continue** with guidance for all household contacts to test daily for five days, and if symptomatic beyond those five days.
Public health rationale	The recent removal of quarantine requirements does not appear to have significantly altered case and hospitalisation numbers. Based on this experience and the current outbreak context, 5-day daily testing of household contacts continues to provide a sufficient risk mitigation.
Other comments	Members of the Committee noted the following concerns with the possibility of changing from the current approach: • change at this time may result in confusion and change fatigue for the public • data does not exist on adherence with the status quo. If most contacts are not following the 5-day testing recommendation a change to recommending testing on symptom onset may have little impact on risk.

Face masks

Current requirement	The requirements for masks are set out in the COVID-19 Public Health Response (Masks) Order 2022. The Order specifies that: • masks are legally required for visitors[13] in a wide range of health service settings including primary care, urgent care, pharmacies, hospitals, aged residential care (ARC), disability-related residential care, allied health, and other health service settings • there are exclusions for: patients and people receiving residential care, health service staff, and visitors to specific health services (psychotherapy, counselling, mental health and addiction services). Requirements for patients and workers of health services are determined locally, based on local assessments in line with Infection Prevention and Control Guidance.

[12] https://handbookgermany.de/en/coronavirus-general-info
[13] COVID-19 Public Health Response (Masks) Order 2022, section 5(1)(a): "A person must wear a mask when they are at the premises of a health service unless the person is a patient or worker of the health service".

Director Public Health recommendation	**Retain** the current requirement as described above.
Public health rationale	The evidence that mask wearing decreases the rate of transmission of COVID-19 (and other airborne respiratory viruses) is substantial. An earlier briefing (HR20221311) provides an overview of the evidence base in relation to mask use, and mask mandates. The effectiveness of mask mandates as a public health intervention will depend on several factors – including the level of community transmission at the point in time, the nature of the settings in which masking is required, cultural and geographical norms around masking, correct mask use, and the extent to which improvements to ventilation/filtration have been enacted as systemic primary prevention. Health service settings have a series of characteristics that elevate the risk of transmission and/or the risk of severe disease. These settings typically: • are more likely than other settings to have people present with undifferentiated viral illness, either because they are seeking help for symptoms or because they have a co-existing medical emergency • are also more likely to have people present who are vulnerable, either due to advanced age, underlying conditions, or to being unwell at the time - facility-level mask requirements lean against inequity, to ensure that people who are at higher risk can access health services without *avoidable* additional risk[14] • have variable ability to improve crowding, indoor ventilation and/or air filtration[15] • hospital-acquired COVID-19 infections are more likely to have poorer outcomes than community-acquired COVID-19 infections.[16] While adherence to mask requirements may be waning or patchy in some health service settings, **it is possible that adherence would drop further if the mandate was removed**. This is evidenced by the decrease in people masking on public transport in the past month (which has remained recommended by the Ministry of Health). Mask requirements lean against inequity, to **ensure that people who are at higher risk can access health services without *avoidable* additional risk**. A conservative estimate is that one in every six New Zealanders is at

[14] A conservative estimate is that one in every six New Zealanders is at higher risk of severe illness if they contract COVID-19 ('Options for improving respiratory protection against aerosolised viral particles for vulnerable and priority populations' (HR20220682), 29 April 2022). Mask mandates in health service settings have two benefits for people in this group: it means that they will (a) be less likely to actually be infected, and (b) be more likely to feel able to continue to safely access healthcare. In many cases people accessing health services are unable to choose not to do so.

[15] Many health service settings don't have good design or engineering so that the added value of masks to protect the vulnerable (patients, staff and visitors) become really important when there is frequent introduction of infection into those environments. This is especially true of healthcare settings in the community, but also remains a real issue in many hospitals. Many older wards are predominantly multibed rooms (often 4-6 bed), shared bathrooms and no doors on rooms. In this context, it is often hard to isolate and improve air filtration.

[16] In Victoria, Australia, 7.6 percent of hospital-acquired COVID-19 infections resulted in death, compared to 0.14 percent of reported cases in the general population in the same period. This demonstrates that infections in hospital settings are associated with significantly (over 50-fold) higher mortality. Victoria Department of Health. 2022. Chief Health Officer Advice to Premier, 29 August 2022. Retrieved from https://www.health.vic.gov.au/publications/chief-health-officer-advice-to-premier

	higher risk of severe illness if they contract COVID-19.[17] Mask mandates in health service settings have two benefits for people in this group: it means that they will (a) be less likely to actually be infected, and (b) be more likely to feel able to continue to safely participate in basic activities of daily life, such as accessing healthcare. In many cases people accessing health services are unable to choose not to do so. Removing mask mandates in health service settings may lead to an **increase in cases of hospital-acquired COVID-19**. Feedback from two districts has noted possible links between visitors and hospital-acquired cases of COVID-19.[18] There is still **value in trying to prevent infections, even for highly transmissible variants.** While it may not be possible to get R_e to below 1 with highly infectious variants/subvariants, there is still significant value in trying to prevent infections where possible, as each new infection (or reinfection) effectively 'rolls the dice' for one or more post-acute sequelae that are known to occur such as long COVID, and increased risk of long term (up to 1 year) cardiovascular complications compared to individuals without COVID-19.[19] Long COVID and other post-acute sequelae have personal costs, but also broader impacts on society, in terms of outcomes such as increased disability, increased welfare and health costs, and reduced workforce participation.[20]
Other comments	*Other options considered* If the mask mandate for visitors to health service settings was removed, it may create some operational challenges, which would need to be worked through at a facility level: • If health care facility is still requiring mask use on site (or in certain higher risk areas within their site) but this is not covered by a mandate, it may result in security/conflict resolution situation for staff to manage if members of public do not wish to follow facility rules. Currently, health services can use the Order to compel visitors. Without mandate, it may be more difficult to deal with a visitor who refuses to wear a mask, and this may become a more common event. Evidence that enforcement of mask policy would be more difficult than mask requirements under an order is limited.

[17] The Ministry of Health does not have precise figures for the number of New Zealanders who meet the definition of being at higher risk. However in April 2022, the number of 'clinically vulnerable' people (which is defined more narrowly than 'high risk') was estimated at 800,000. 'Options for improving respiratory protection against aerosolised viral particles for vulnerable and priority populations' (HR20220682), 29 April 2022.

[18] *"Anecdotally, visitors have featured in many in-hospital transmission events in many units, especially geriatrics/rehab wards which have a high proportion of vulnerable patients. This may have been due to lapses in mask compliance by visitors during the visit (eg, sharing a cup of tea, or kissing/hugging patient)." "We have had a number of clusters and outbreaks here and when COVID is everywhere, it is difficult to attribute outbreak sources with any degree of certainty. The relevant ward nurses felt that several of our events were likely caused by infectious visitors. At the time, mask wearing behaviour by visitors was frankly poor and some visitors became abusive when asked to wear masks."*

[19] See Ballering AV, van Zon SKR, olde Hartman TC, Rosmalen JGM. 'Persistence of somatic symptoms after COVID-19 in the Netherlands: an observational cohort study'. The Lancet. 2022;400(10350):452-61; and Xie Y, Xu E, Bowe B, Al-Aly Z. Long-term cardiovascular outcomes of COVID-19. Nature Medicine. 2022;28(3):583-90.

[20] For example an August 2022 report from the Office for National Statistics in the UK estimated that 1.8 million people living in private households were experiencing self-reported long COVID (symptoms continuing for more than four weeks after the first suspected COVID-19 infection that were not explained by something else) see https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/4august2022.

	• Health services would need to consider implications on patients/residents exposed to visitors, and the potential for an increase in patients developing hospital-acquired COVID-19 infections. • If the mask mandate for visitors is removed and most visitors are not wearing masks, one service reported that they may need to consider implications for staff mask requirements. They considered that it could be hard to defend mask use around patients if other (non-staff) people entering the clinical zone are not required to wear them. *Clear public communication is critical under all options* Key to success of any of the options is the clear communication of the strategy to the public and to healthcare workers. It is also important to signal that we may need more widespread use of masks again if community transmission increases. *Health services situated within other settings* The Committee reaffirmed that where a health service that is situated entirely within a non-health service (eg, a pharmacy within a supermarket, or a physio within a gym) the health service is expected to comply with the Order.

Provision of information using the New Zealand Traveller Declaration for contact tracing prior to departure

Current requirement	Air travellers coming to New Zealand are required to declare, before they arrive, their contact details and travel history through the NZTD for the sole purpose of COVID-19 contact tracing, should they need to be urgently contacted in response to a serious new variant of concern. This requirement is the only substantive remaining health requirement in the COVID-19 Public Health Response (Air Border) Order 2021.
Director Public Health recommendation	**Remove** the requirement under the Air Border Order, with effect from 05 November 2022, for air travellers to New Zealand to provide information using the NZTD for COVID-19 contact tracing purposes prior to departure.
Public health rationale	The mandatory requirement is not considered proportionate in the current context. The requirement relates to a potential future risk and not an immediate or likely variant requiring action shortly. However, having air traveller contact details and travel history electronically collected using the NZTD supports a more efficient and accurate dataset of passenger information should contact tracing be required. While the likelihood of needing to stand-up contact tracing of air passengers is considered low in the current context, the rate at which SARS-CoV-2 continues to mutate means that we need to ensure our systems remain prepared. Given the value of this measure, NZ Customs have indicated the requirement can be continued under the Customs and Excise Act 2018 should there no longer be a public health rationale to do so.

	Continuing the requirement under Air Border Order until the amended Customs (Arriving Passenger and Crew Declarations) Rules 2022 comes into force on 5 November means that there will be a seamless transition and the ability to contact passengers in the intervening period will be retained.
Other comments	The most likely scenario where contact tracing may be required would be a new variant that has high severity, high immune escape and low transmissibility. Contact tracing is likely to be of limited value in response to a serious new variant of concern in the absence of other restrictive measures (such as border closures, pre-departure testing, post-arrival isolation).

Testing of arrivals at the air border

Current requirement	Air arrivals are encouraged to do a RAT on the day of arrival (0 or 1) and on day 5 or 6 and to report a positive test result via phone or My Covid-Record. If positive, they are encouraged to get a free polymerase chain reaction (PCR) test from a community clinic or GP, so this can be available for whole genome sequencing.
PHRA recommendation	**Modify** the post-arrival testing guidance for all travellers to test if symptomatic only.
Director Public Health recommendation	Advising all international arrivals at the air border to test on day 0 or 1 and on day 5 or 6, when asymptomatic, is not proportionate given the lower prevalence of COVID-19 currently circulating globally, the relatively high impost on travellers, the cost of providing and distributing the RATs at the airport and the risk of false positives. *Relative effectiveness* Post-arrival testing provides additional (early) surveillance of new variants that may be entering the border. However, the 1-to-2-week lag time from the point of arrival to having a result from a positive PCR genomically sequenced means testing at the border is unlikely to detect new variants arriving in the country before community spread of these variants occurs. Moreover, based on the drop off in PCR testing numbers, it is assumed adherence to this guidance is low. *Equity* There are equity concerns around the testing performance of large groups of asymptomatic people because of the testing performance of RATS. For testing performance of RATS:[21] [22] • the false positivity rate is approximately 1%-2%

[21] Ministry of Health. 2022. *Approved RATs and how to use them (as at 26 May 2022*), viewed on 5 October 2022 https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-health-advice-public/covid-19-testing/rapid-antigen-testing-rat#regulatory.

[22] *Indelicato AM, Mohamed ZH, Dewan MJ, Morley CP. Rapid Antigen Test Sensitivity for Asymptomatic COVID-19 Screening. PRiMER. 2022 Jun 22;6:18. doi: 10.22454/PRiMER.2022.276354. PMID: 35812789; PMCID: PMC9258726. /*

	• only have a 50% sensitivity rate of detecting COVID-19 in an asymptomatic person • have an 80-90% sensitivity rate of detecting COVID-19 in symptomatic people. This will result in isolation of individuals who do not have COVID-19, while some people with an acute COVID-19 infection may not be identified in surveillance testing using RATs (even when compliance is high). *Cost* The cost of providing and distributing free RATs for asymptomatic testing of all arrivals is also a consideration. Weekly air traveller volumes for the last three weeks have been around 70,000 per week, so cost of the RATs alone is just over $2 million per week. Further, there is the cost per month of Health Care Logistics (HCL) to pack and distribute the packs, which was approximately $895,000 for September due to the reworking on the packs following the changes and will be $550,000 for October (school holiday increase) and $490,000 for November. Air traveller volumes are expected to reach 100,000 by the end of the year. If adherence is as low as assumed, this expense is uneconomic.
Other comments	*Support at airports* Te Whatu Ora have advised that as there is limited health presence at the border to provide screening and identification of symptomatic people, and RAT packs should no longer be provided at the border. Instead, symptomatic people should collect RAT packs at a community collection site (sites are available on healthpoint.co.nz) and encouraged to test and if test positive, they should be encouraged to go for a PCR test. *Maritime border requirements* Arrivals from the maritime border are not advised to test if coming ashore. Instead, they are encouraged to follow community testing guidelines, that is, to test if symptomatic.

Other recommendations from the PHRA

28. There were other recommendations arising from the PHRA. They primarily related to actions or information that could support future PHRA discussions. These include:

    - The development of a pathway for transitioning away from our current position and the basis for that, particularly for case isolation. Work is currently underway on this as part of the variants of concern and preparedness plan.
    - A report back on further work undertaken by the Ministry of Health on allowable permitted movements of cases. Two scenarios were discussed at the PHRA, but further work was needed to identify how this matter could be addressed more generally to deal with a range of scenarios given that expanding the list of permitted movements could begin to undermine the rationale for self-isolation.
    - Explore options for any improvements for data and modelling related to reporting on vulnerable populations (Māori, Pacific, disabled, and high deprivation) to improve

decision making. It was requested this updated information be provided at the next PHRA.

- Related to the above, the impacts of long COVID need to be included in the data and modelling to provide a more comprehensive assessment of the risks and impacts of COVID-19.

Equity and Te Tiriti considerations

Impact of COVID-19 on vulnerable populations

29. Demonstrating a commitment to the achievement of health equity and Te Tiriti o Waitangi remains a critical priority in the COVID-19 public health response. COVID-19 has exacerbated pre-existing health inequities for many groups, particularly those underserved by the existing system. This is often due to overlapping social, clinical, and occupational risk determinants.

30. As shown in **Appendix 1**, older people are more likely to be hospitalised and this is reflected in the latest data. As the virus takes longer to move through this population due to this group having fewer social interactions it may lead to a higher hospitalisation burden over a longer period.

31. The *COVID-19 Mortality in Aotearoa New Zealand: Inequities in Risk* report, released 30 September 2022 highlights the disparity of the impacts of the pandemic. Overall mortality continues to decline. However, after adjusting for age, comorbidities and vaccination status, the report showed that the risk of COVID-19 mortality in Māori is 2.2 times higher than that of European and Other group, while for Pacific Peoples the risk was 2.8 times higher.[23]

The risk of COVID-19 mortality reflects adjustments for age, as opposed to comorbidities and vaccination status

32. Pacific Peoples continue to be disproportionately affected by COVID-19. Moreover, they continue to experience long-standing inequitable health outcomes and service use. Recent data shows Pacific Peoples are the demographic most hospitalised for COVID-19.[24]

33. Disabled people and those with underlying medical conditions are more likely to be hospitalised or require medical intervention/support if they test positive with COVID-19. While deprivation is a proxy, the Committee noted that there is no data and modelling of hospitalisation and mortality data for disabled communities.

34. While cases and hospitalisations continue to trend downwards overall, several Committee members expressed strong reluctance to removing self-isolation and mask requirements, without focused modelling on how this would impact Māori, tāngata whaikaha Māori and disabled people. Current modelling on potential policy changes forecasts impacts such as case numbers, hospitalisations and mortality for the general population, but it does not forecast impacts of policy changes for vulnerable groups. The Committee therefore made its recommendations using the precautionary approach. Development of modelling to specifically assess equity impacts will assist in addressing this issue.

35. Mandatory self-isolation requirements provide an important safeguard against workers with COVID-19 returning to work before they have recovered. The Māori Regional Coordination Hub has indicated that wider consultation should accompany any removal of the self-

[23] Ministry of Health. 2022. *COVID-19 Mortality in Aotearoa New Zealand: Inequities in Risk.* Wellington: Ministry of Health
[24] Ibid.

isolation requirements as it would disproportionately affect the Māori community. Recommending the retention of self-isolation requirements would help to ensure that those most vulnerable continue to be able to rest and recover while ill, and do not spread the virus further among their potentially vulnerable community. Retention of the Leave Support Scheme will help mitigate these risks.

36. Committee members highlighted that the more distant disproportionate impacts of long COVID on vulnerable groups must be considered when assessing the public health risk of stepping down measures. Māori, Pacific Peoples, disabled people and elderly are at greater risk of developing long COVID and suffering worse health outcomes than the general population. Māori, for instance, may suffer long COVID for longer than non-Māori. In one study, 75% of Māori participants had long COVID for more than three months, compared to only 65% of non-Māori.[25]

Stakeholder engagement and key issues and themes emerging

37. Across the board there was strong support for retaining the current mandated measures to protect vulnerable communities. The move away from the Elimination Strategy and removal of other mandatory requirements were considered to put these communities at greater risk.

38. The removal of border restrictions and the threat of new variants easily entering the community is a particular concern for groups with already compromised immunity, limited access to anti-viral medication and concerns about the relative effectiveness of vaccinations against new variants.

39. The changes have caused anxiety in these communities, especially amongst disabled people. People are choosing to make individual risk assessments that have resulted in ongoing isolation or limited interactions with others in their community. Assurances are also being sought from providers concerning the vaccination of their staff and the ability to require face masks for home visits.

40. More generally, there is a concern that the community at large may not take the risk of COVID-19 seriously and put vulnerable populations at greater risk. As noted previously, there is a strong preference among vulnerable communities for the elimination of COVID-19. Emerging from this is a desire to build "borders" around these vulnerable populations through either differentiated public health responses or the retention of current requirements to ensure that people exercise the behaviours necessary to limit the mortality and morbidity amongst these populations.

Addressing equity concerns

41. It is important that the measures are not viewed in isolation. The new approach to managing COVID ("prepared, protective, resilient, and stable") is predicated on using a suite of voluntary and enforceable measures to address both general and specific risks. A package of measures could be developed that provides for an effective and proportionate response to manage the risk of COVID-19 and improve equity outcomes for Māori, Pacific and disabled communities.

42. For example, based on the feedback received at both the PHRA and from stakeholder engagement, significant gains can be made through improved communications and

[25] Ministry of Health. 2022. *Long COVID Evidence Update - 11 August 2022*. Wellington: Ministry of Health. 16.

programmes targeted to those communities. Other system supports like the Leave Support Scheme could also prove crucial to encouraging the behaviours being sought.

43. Enforceable or mandatory measures can also be re-introduced if the COVID-19 situation significantly changes. This would be an effective and proportionate response to a worsening risk profile. While such rights limiting measures may be more controversial than they have been in the past regarding the social licence, the legal test remains the same.

44. s9(2)(f)(iv) [redacted]

New Zealand Bill of Rights Act 1990 (Crown Law Office advice)

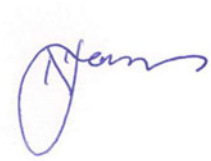
45. The paper proposes to maintain the current 7-day isolation period for positive cases (with guidance for household contacts to test daily for 5 days) and retain face mask requirements for visitors on the premises of health services.

s9(2)(h) [redacted]

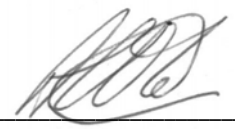
d. s9(2)(h) [redacted]

Next steps

52. Pending your approval, this memo will be provided to the Department of the Prime Minister and Cabinet to inform the overarching paper the Minister for COVID-19 Response will take to Cabinet on 17 October 2022.

Signature  Date: 12 October 2022

Dr Nicholas Jones
Director of Public Health
Public Health Agency
Manatū Hauora

Signature  Date: 12 October 2022

Dr Andrew Old
Deputy Director-General
Public Health Agency
Manatū Hauora

Signature  Date: 12 October 2022

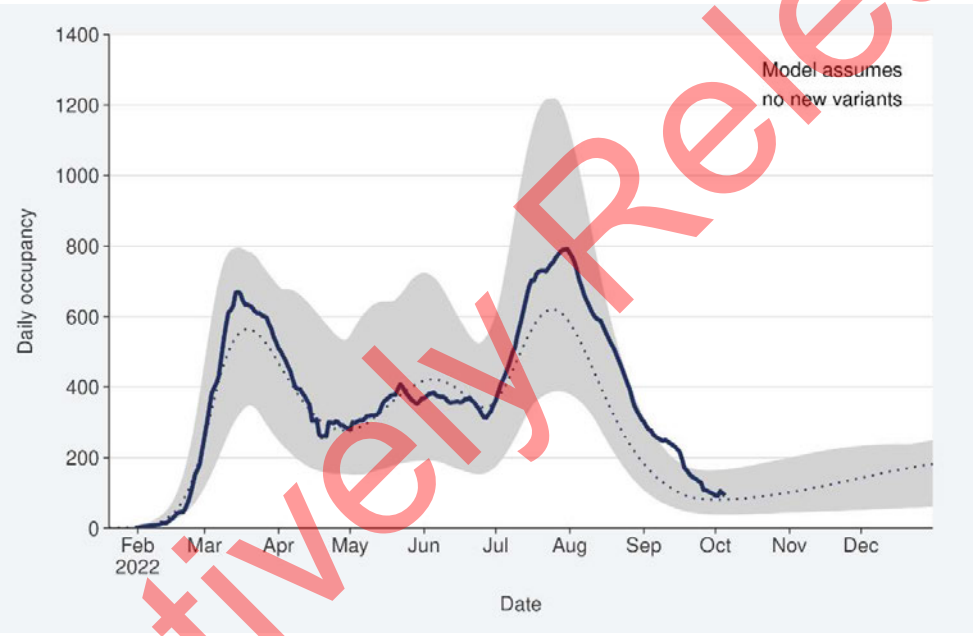
Dr Diana Sarfati
Director-General of Health
Manatū Hauora

Appendix 1: Current outbreak status and summary of modelling

1. The 7-day rolling average of reported case rates was 32.2 per 100,000 population for the week ending 09 October. This was a 11% increase from the previous week, which was 28.6 per 100,000.

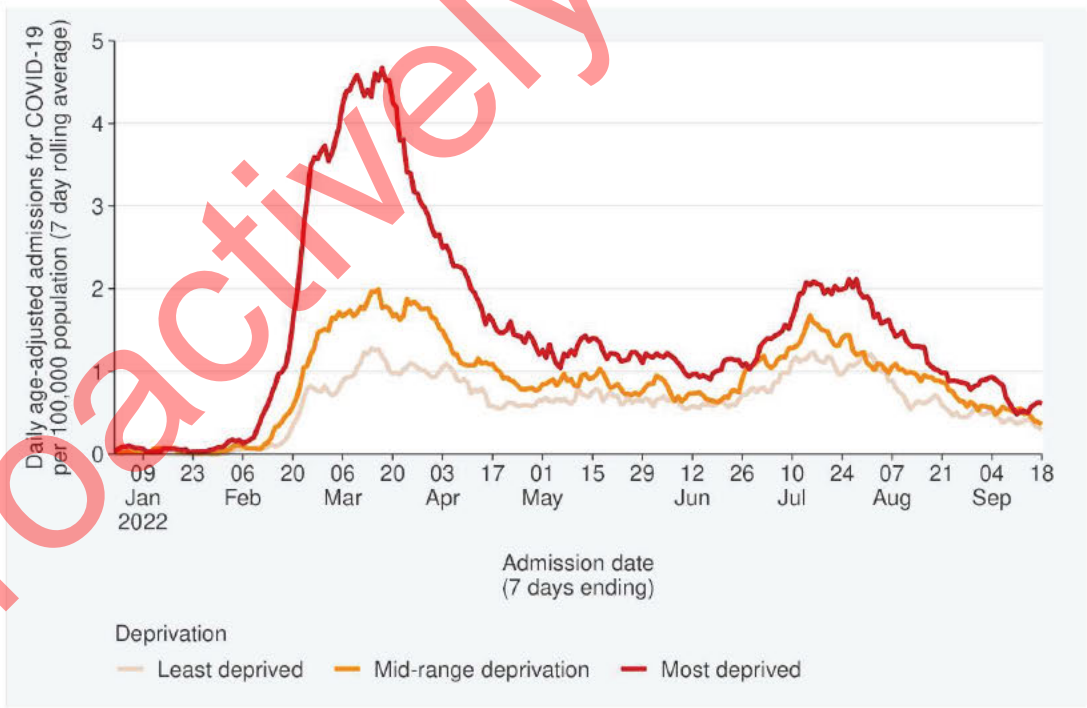
2. All evidence continues to support stabilisation in incidence in the community: reported case rates and levels of viral ribonucleic acid (RNA) in wastewater have been declining since 10 July but both measures have been relatively constant in the recent weeks to 02 October. The trend was similar for all regions.

3. Modelling scenarios suggest that current hospital occupancy is tracking near the higher range of the prediction for the past two months. It is now tracking closer to the median projection and is expected to remain stable or slightly increase in the coming months. Modelling scenarios account for changes in masking and contact quarantine on 12 September and assume no new variants.



4. The age-standardised Māori cumulative hospitalisation rate for COVID-19 is 2.1 times higher than European or Other. Pacific Peoples have the highest cumulative rate of hospitalisation with COVID-19 which is approximately 2.8 times higher than European or Other.

5. Those most deprived communities have had, and continue to have, the highest rates of hospitalisation, both recently and cumulatively during 2022. Those most deprived communities have had 2.1 times the risk of hospitalisation compared with those who are least deprived.



6. As of 09 October, there were 2,055 deaths attributed to COVID-19. The weekly number of deaths attributed to COVID-19 has stabilised.

7. The modelling results have been produced rapidly to help inform policy advice. They should be considered as indicative as there are significant uncertainty around the impact of policy changes and the level of immunity in the population and population behaviour.

8. Modelling has considered a range of scenarios to reflect this uncertainty by estimating pessimistic, middle, and optimistic scenarios, reflecting different levels of compliance with **guidance on isolation,** specifically to estimate the effect of shift away from mandated isolation requirements, should the Epidemic Notice be lifted.

9. Within the first month, shifting isolation **requirements** to 5-days guidance **no** test to release (TTR) is modelled to **increase cumulative hospitalisations by roughly 450 to 1040 and increase deaths by 50 to 170**, relative to no change in policy. Over a year, these **increases are 7900 to 8900 for hospitalisations and 1860 to 2160 for deaths.**

10. Within the first month, **shifting to a requirement** to TTR after 5 days for a maximum of 7 days is modelled to **increase hospitalisations by roughly 45 to 640 and increase deaths by 6 to 120. Over a year, these increases are 7900 to 8050 for hospitalisations and 1870 to 1900 for deaths.**

11. Moving to 5-days TTR maximum 7-days guidance is modelled to **increase hospitalisations by roughly 300 to 890 and increase deaths by 40 to 150**, relative to no change in policy. Over a year, these **increases are 7900 to 8600 for hospitalisations and 1870 to 2080 for deaths**.

12. Across the scenarios**, for-covid hospital occupancy peaks at between 200 and 304 beds**, compared to a peak of 700 beds in the BA.5 wave. When looking at the high confidence limit of these estimates, for-covid hospital occupancy still peaks below the BA.5 wave peak at around 402 beds.

13. **Importantly,** the model assumes no new variants, therefore the long-term results do not reflect the likely path of the pandemic. If an immune escape variant should arise, the estimates for above will change and the modelled results will no longer be valid.

14. In general, the short-term peak in cases and hospitalisations can be mitigated by phasing policy changes over a longer period of time.

15. **A note on Rt sensitivity and asymptomatic cases**: Given the sensitivity of RATs through time, a rule that says to only test on the first day of symptoms will miss a large number of cases. Additionally, 30-40% of infections are asymptomatic.

16. An important caveat is the equity impacts of these changes have not been modelled, in part due to limited available data, but also limitations of the models. However, observations of prior disease burdens for COVID-19 and based on general observations across public health, moving some settings from mandates to guidance will **likely lead to inequitable outcomes**.

    a. Māori and Pacific peoples are more at risk of severe negative health outcomes than non-Māori non-Pacific Peoples of the same age, and are also more likely to experience greater disease exposure.

    b. Poorer people are at greater risk of severe negative health outcomes than affluent people of the same age, and are also more likely to experience greater disease exposure.

    c. Shifting to guidance is likely to disproportionately affect those who do not have the ability to choose to follow the guidance. This may include: people in precarious

employment, those unable to work from home, workers with limited sick leave and populations with other socioeconomic disadvantages.

17. Additional supports for people to isolate effectively (such as additional sick leave and maintaining the leave support scheme in some form) could help mitigate these inequitable outcomes and increase the ability for more people to follow guidance on isolation.

How do reductions in the share of cases choosing to isolate affect the reproductive number?

18. Modelling has considered how two factors affect the reproductive number (which drives the level and speed of transmission):

    a. A reduction in the share of infections taking any action to reduce transmission. This could be due to people ignoring their positive result or choosing not to test at all.

    b. A reduction in the average effectiveness of action to reduce transmission. This could be due to people isolating for a shorter period of time, or only avoiding high risk settings.

19. Furthermore with regards to mandatory isolation, the model assumes that 70% of symptomatic infected individuals will be detected and that they take action to reduces transmission outside the household by 90% (ie, a 'case leak rate' of 10%).

20. The table below shows the increase in the reproductive number for a range of different assumptions. It takes into account changes made to masking and contact quarantine settings on the 12 of September. Percentage increases beyond that vary significantly from 2.1% to 16.7%. In general, having a large share of cases taking some action is more effective than some cases taking significant action.

		Reduction effectiveness of actions				
		0%	25%	50%	75%	100%
Reduction in proportion of people taking action	0%	2.1%	5.6%	8.3%	10.4%	12.1%
	25%	6.3%	8.7%	10.4%	12.0%	13.3%
	50%	10.0%	11.5%	12.7%	13.7%	14.4%
	75%	13.7%	14.1%	14.7%	15.2%	15.7%
	100%	16.7%	16.7%	16.8%	16.9%	16.8%

Behavioural impact examples

21. Data from the UK suggests (based on surveys conducted by the UK Office of National Statistics) around a month after isolation requirements were relaxed to guidance, the proportion of people isolating **after testing positive** was just over 50%, while the proportion of people taking precautions **after testing positive** (eg, wearing masks in public, avoiding indoor settings) was just over 40%, both showing significant decreases in transmission mitigating behaviour.

22. If New Zealand follows a "UK-like" scenario, there may be an increase in transmission by around 12.7%.

23. If there was a 50% reduction in the proportion of symptomatic infected people taking action, (compared to September 2022), but no reduction in the effectiveness of the action

taken, then we estimate that the effective reproduction number would increase by 10% (relative to the effective reproduction number in September 2022).

Scenarios considered

24. Modelling has considered adjustments to current mandatory isolation settings as well as moving to guidance for isolation. For scenarios with mandatory isolation, two changes are considered: reducing minimum isolation to 5-days with one negative test required before release and a maximum of 7-days isolation; and reducing isolation to 5-days, with no test to release. Previous modelling suggests that these scenarios would increase the reproductive number by 1.4% and 4.2% respectively.

25. Modelling has also considered scenarios where guidance is used for isolation. Because of the significant uncertainty in how people respond to a removal of mandated case isolation, modelling has considered three scenarios:

    a. An optimistic scenario, with a 7.8% increase in the reproductive number.

    b. A middle scenario, with a 11% increase in the reproductive number.

    c. An upper limit scenario, with a 17.5% increase in the reproductive number. This is slightly higher than the highest increase in the table above, due to small differences in assumed symptomatic testing rates.

26. Finally, modelling has considered a scenario where no changes are made to case settings, but guidance for household contacts is changed to testing every 48 hours if symptomatic. Compared to the status quo of testing daily for five days, this results in a 3.3% increase in the reproductive number.

27. Factors that would shift New Zealand towards the optimistic scenario could include:

    a. achieving high levels of testing in the community

    b. maintaining strong norms that people should work from home if unwell

    c. high voluntary adherence to mask and case isolation guidance

    d. importance of clear communications and assistance (eg, leave support schemes) that would allow people to both understand the importance of these, and be able to do these

    e. advice to employers to encourage work from home where possible for unwell people.

Modelling results

28. Policy changes that increase transmission will tend to have two effects:

    a. In the short-term, a large increase in cases, hospitalisations and deaths. The absolute size of this change will be driven by the level of immunity in the population. This impact wanes over time as infection-induced immunity increases.

    b. In the long-term, a slightly higher steady state level of cases, hospitalisations and deaths. This impact is smaller in percentage terms but is persistent over time.

29. In general, the short-term peak in cases and hospitalisations can be mitigated by phasing policy changes over a longer. This smooths out the peak and allows decision makers to adjust their approach if the path of the outbreak differs from modelled projections.

30. The table below shows the increase in cases, hospitalisations and deaths under these scenarios. In the short-term, there is a large relative increase in cases, hospitalisations and deaths. Relative increases are smaller over the long-term, but larger in absolute terms.

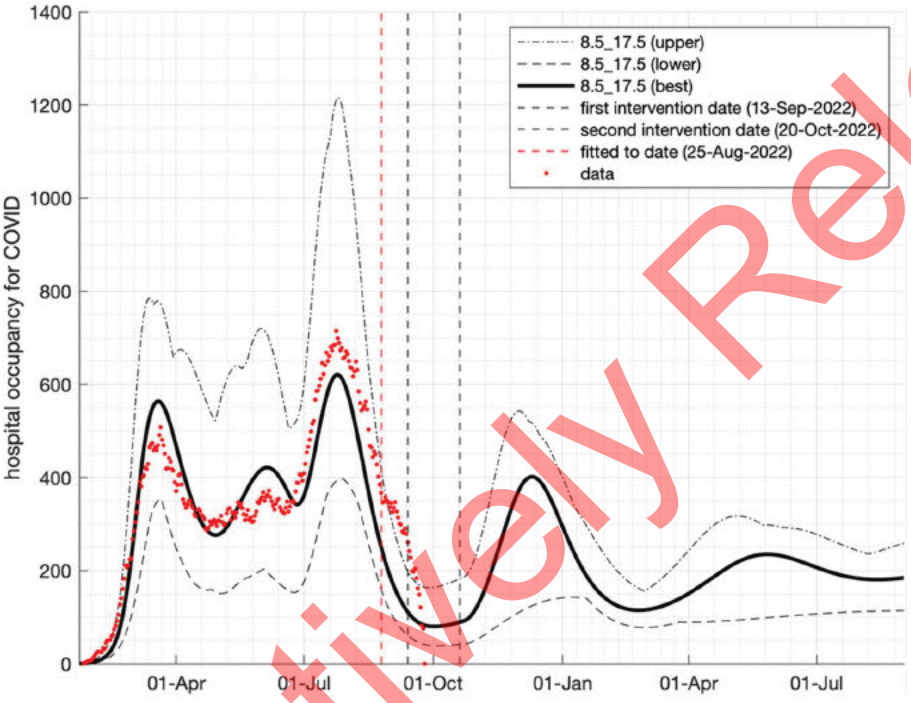
31. Compared to the table presented in the memo on isolation changes, short-term cases, hospitalisations and deaths tend to be higher across all scenarios, including the baseline. This partially reflects the changes are being made on top of policy changes already made in September. In addition, the policy change is occurring during a plateau in cases, compared to the downward trend during September.

	Short-term impact (cumulative from 15 days after implementation to 45 days after implementation)			**Long-term impact (cumulative for a year after implementation)**			**Peak for-covid hospital occupancy**
	Cumulative cases	*Cumulative hospital admissions*	*Cumulative deaths*	*Cumulative cases*	*Cumulative hospital admissions*	*Cumulative deaths*	
Status quo	63278	591	115	829516	7919	1864	191
Scenario 2 – Mandatory 5 days TTR (maximum 7 days)	68126 (+7.7%)	636 (+7.6%)	121 (+5.2%)	840854 (+1.4%)	8050 (+1.7%)	1904 (+2.1%)	199 (+4.2%)
Scenario 3 – Mandatory 5 days (no TTR)	78848 (+24.6%)	736 (+24.5%)	133 (+15.7%)	862653 (+4.0%)	8303 (+4.8%)	1981 (+6.3%)	222 (+16.2%
Scenario 4 – Guidance 5 days TTR (maximum 7 days)	94750 (+49.7%)	885 (+49.7%)	151 (31.3%)	889181 (+7.2%)	8615 (+8.8%)	2077 (+11.4%)	262 (+37.2%)
Scenario 5 – Guidance 5 Days (No TTR)	110966 (+75.4%)	1039 (+75.8%)	169 (47.0%)	911582 (+9.9%)	8881 (+12.1%)	2161 (+15.9%)	304 (+59.2%)
Scenario 6 – Guidance 5 Days (No TTR) upper limit Rt	149521 (+136.3%)	1412 (+138.9%)	213 (85.2%)	954540 (+15.1%)	9397 (+18.7%)	2324 (24.7%)	402 (+110.5%)
Scenario 7 – status quo and HH test only if symptomatic	75249 (+18.9%)	702 (+18.8%)	129 (12.2%)	855767 (+3.2%)	8223 (+3.8%)	1956 (4.9%)	214 (+12.0%)

32. The figure below shows for-covid hospital occupancy for the upper limit scenario (other scenarios shown further below). Note these figures may not align reported in the Ministry of Health press release, as those figures include with-covid hospitalisations.

33. The model projects hospital occupancy falling to around 100 occupied beds in early October. The policy change results in an increase in hospitalisations over the following months. The best fit of the model peaks at roughly 400 beds, however the uncertainty around this peak ranges from around 550 occupied beds on the high end, to under 150 beds on the low end. Despite the large increase in transmission, the modelling suggests that accumulated immunity would keep peak hospitalisations below the BA.5 wave peak.

Figure 1: Impact of upper limit scenario on for-covid hospital occupancy



34. The shape of the hospital occupancy curve is broadly similar for the optimistic and middle scenarios (shown further below), but with peak hospital occupancy being around 250 beds (optimistic) and 100 beds lower (middle) than the pessimistic scenario.

Assumptions

35. This modelling uses a large number of assumptions that are important to keep in mind:

    a. **Mask mandate assumptions**. Mask mandates are assumed to reduce mask usage that in turn causes a roughly 20% reduction in transmission outside the home.

    b. **Contact quarantine assumptions**. This modelling uses very similar assumptions to those used in the August monthly review of case isolation and contact quarantine.

    c. **Case isolation assumptions**. With mandated 7-day isolation, it is assumed that 90% of transmission for identified cases is prevented.

d. **Long-term trajectory assumptions**. The model assumes that BA.5 is the prevalence variant for the next 12 months and no changes to vaccination eligibility (eg, third boosters, second boosters for more groups) and no change in available therapeutics.

e. **The model assumes no new variants.** The simulations do not account for new variants of concern and the impact of circulation on case, hospitalisations and deaths.

f. **Peaks and troughs assumptions.** Because this is a single national model, it may not capture the different size, shape and timing of peaks at a district or regional level. Therefore, the model may overestimate peaks and underestimate troughs, if outbreaks in different population groups are not aligned.

g. **Uncertainty around modelled estimates.** The provides confidence intervals around estimates of cases, hospitalisations and deaths. This range reflects unknowns such as the share of infections detected and the speed of waning immunity. The model is fit to data up to 25 August, which reduces some of this uncertainty.

h. **Uncertainty around "guidance" vs "requirements".** It is difficult to say what model parameters to use to model the difference between mandates and guidance. Compliance and behaviours under a 'guidance' scenario will depend not only on what level people are inclined to follow guidance but also the level of communication around guidance. The table above which presents the effect of varying the proportion of symptomatic infections who take action, and the effectiveness of these actions, gives an idea of what moving between different levels of behaviour might look like for a range of assumptions. However, the actual effect of having guidance is between zero, and some unknown at this point.

Appendix

Figure 2: Impact of optimistic scenario on for-covid hospital occupancy

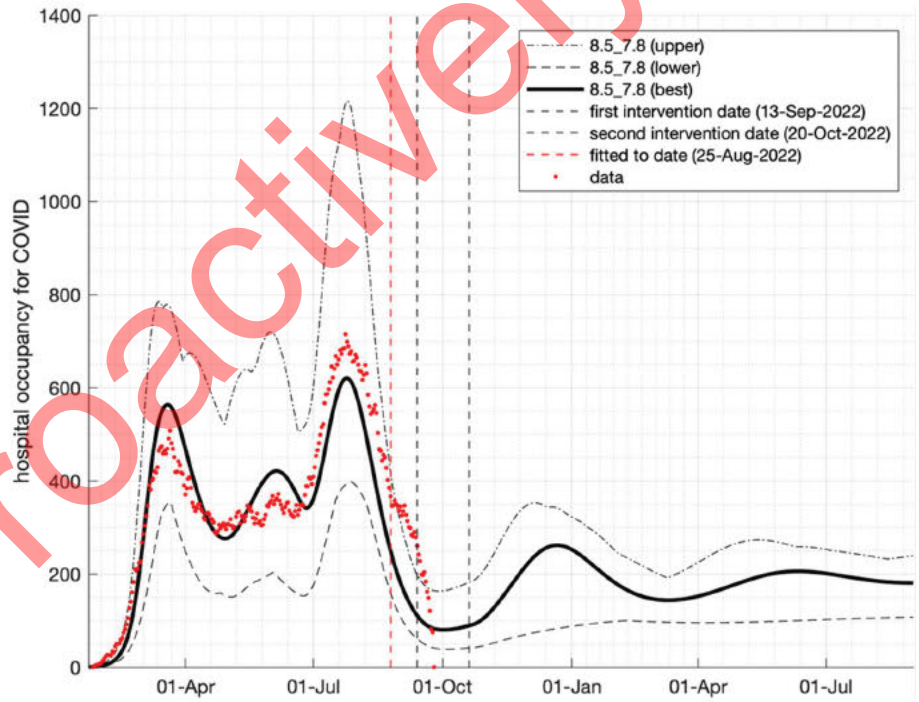
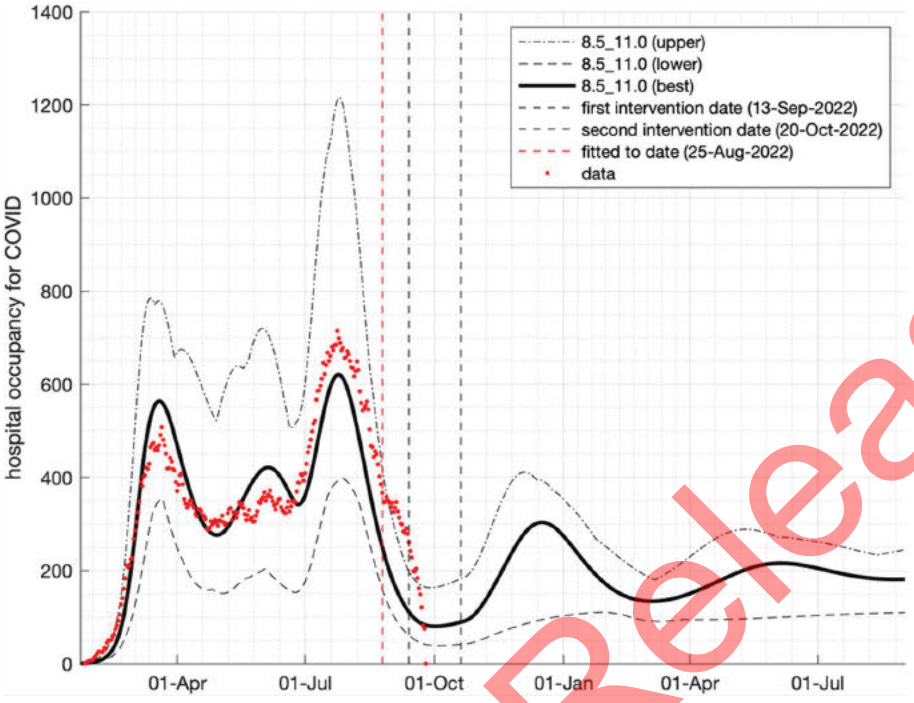
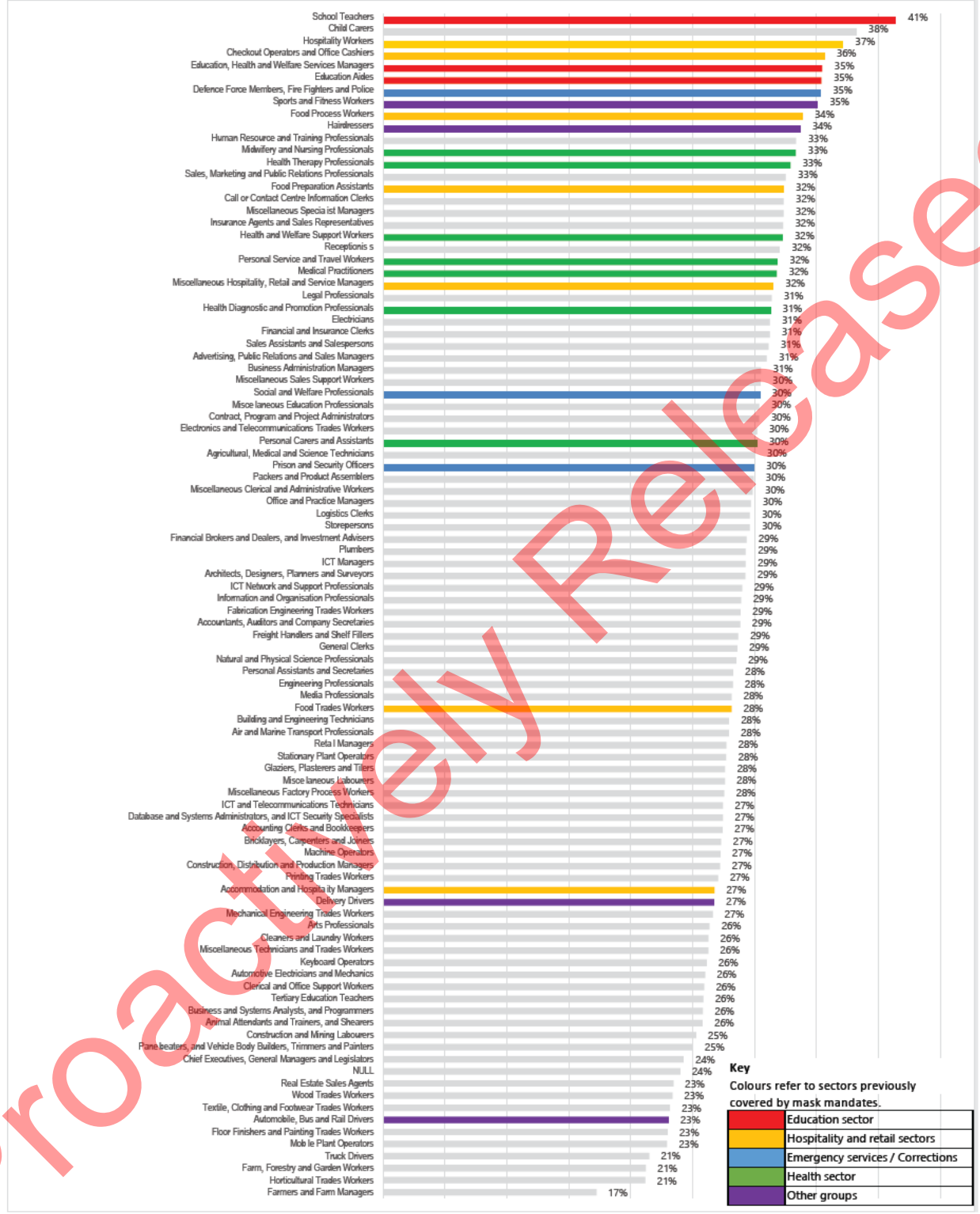


Figure 3: Impact of middle scenario on for-covid hospital occupancy



Appendix 2: COVID-19 case rates by ANZSCO L3 occupational group[26]



[26] Data comes from the Integrated Data Infrastructure (IDI) (StatsNZ). These are crude rates and are from self-reported community testing, which may or may not indicate an increased risk of transmission in that setting, but that could indicate an increased risk of workers being infectious in their workplace setting. Occupation relates to the person's primary job. Data includes all cases to 14 August 2022.

ENDS.

Appendix Two: Regulatory Impact Statement

Regulatory Impact Statement: October review of remaining COVID-19 measures under the new approach

Coversheet

Purpose of Document	
Decision sought:	*Analysis produced for the purpose of informing: October review of remaining COVID-19 measures under the new approach*
Advising agencies:	*Manatū Hauora – Ministry of Health* *Department of the Prime Minister and Cabinet*
Proposing Ministers:	*The Minister for the COVID-19 Response*
Date finalised:	*14 October 2022*

Problem Definition

The COVID-19 context is currently changing, given the recent reduction in case numbers and hospitalisations, as well as moving to a new strategic approach to managing the pandemic.

Given this context, the Ministry of Health has reviewed policy settings to ensure the response remains effective, justifiable and proportionate under the Bill of Rights Act 1990. In particular, the measures that were considered are:

1. provision of information by air arrivals for COVID-19 contact tracing
2. 7-day case isolation requirement
3. point of care tests regulation
4. current masking requirements for visitors in health care settings.

Executive Summary

- *What stakeholders and the general public think – are there any significant divergences in their views that should be brought to Ministers' attention?*

This Regulatory Impact Assessment Statement provides details on the policy analysis and public health review to inform a number of changes to the legal framework for managing the ongoing COVID-19 Pandemic.

This review has focussed on the legal requirements or mandates currently prescribed in the Orders under the COVID-19 Public Health Response Act 2020. To ensure the proposals are effective, justifiable and proportionate under the Bill of Rights Act 1990 and consistent with the requirements in the COVID-19 Public Health Response Act 2020, we have drawn on analysis including:

- information from the Public Health Risk Assessment process
- detailed assessment of options against the criteria for the ongoing strategic approach
- Te Tiriti o Waitangi analysis, and Equity analysis.

Based on an overall assessment, the recommendations are to:

a. remove the requirement to provide information by air arrivals for COVID-19 contact tracing
b. maintain the current 7-day case isolation requirement
c. retain point of care tests regulation
d. remove and replace the current masking requirement in healthcare settings with guidance for health services to set mask policies.

Feedback from Regional Leadership Groups consisting of iwi, local government and community leaders, had mixed views on each of the proposals. These groups noted the positive health outcomes of restrictive measures but also discussed the human rights implications and questioned the feasibility of maintaining compliance with measures.

Feedback from population and vulnerable groups (as part of the stakeholder engagement informing Public Health Risk Assessment) expressed support for maintaining the status quo and for restrictive measures in general. These groups emphasised the potential risks of removing restrictive measures to vulnerable populations, but did not discuss the impacts on human rights or the context of reducing case numbers and hospitalisations.

Where changes are required, they are readily implementable through order changes and supporting public health initiatives. Consideration has been given to whether these changes can be re-instated if required for future variants of concern and this will be possible.

The public health measures will remain under regular monitoring and review, including through regular Public Health Risk Assessments

Limitations and Constraints on Analysis

This proposal is subject to a number of limitations:

- limited time to prepare this Regulatory Impact Statement
- data from modelling results is subject to significant uncertainty around the impact of policy changes and the level of immunity in the population and population behaviour
- limited time for detailed equity and Te Tiriti o Waitangi analysis, and due to timeframes and sensitivity, wider engagement has not been possible.
- limited stakeholder engagement.

While these limitations are present, the use of the Public Health Risk Assessment involving public health, policy, legal, operations and Māori health expertise and drawing on detailed data and evidence provides a robust process for consideration of public health changes at pace. This has been supported by further stakeholder engagement, primarily conducted by the Department of the Prime Minister and Cabinet (DPMC).

Responsible Manager(s) (completed by relevant manager)

Alice Hume

Head of Strategy and Policy

COVID-19 Group

Department of the Prime Minister and Cabinet

14 October 2022

Stephen Glover
Group Manager, COVID-19 Policy
Strategy, Policy and Legislation
Manatū Hauora

14 October 2022

Quality Assurance (completed by QA panel)	
Reviewing Agency:	Manatū Hauora and the Department of the Prime Minister and Cabinet
Panel Assessment & Comment:	A QA panel with members from DPMC and the Ministry of Health has reviewed the Regulatory Impact Statement and considers it partially meets the quality assurance criteria. The analysis of the options is good, and the criteria used are appropriate. However, as the authors note, there has been limited consultation, and equity considerations are only lightly covered. To some extent this is mitigated by the public health risk assessment referred to, but equity should be more closely monitored in implementation.

Section 1: Diagnosing the policy problem

What is the context behind the policy problem and how is the status quo expected to develop?

On 12 September 2022, the Government moved away from the COVID-19 Protection Framework (CPF) to a new approach to managing COVID-19 [CAB-22-MIN-0380]. This included the removal of several mandatory measures including:

- remove the post-arrival testing requirement for all arrivals to New Zealand and replace it with other targeted surveillance and information provision measures for travellers
- remove the COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand (including for air crew)
- remove the requirement for household contacts to quarantine for 7 days, and replace it with guidance to test daily for five days, pending the outcome of wider consultation
- revoke the COVID-19 Public Health Response (Vaccinations) Order 2021 and remove the remaining vaccination mandates for health and disability sector workers.

This decision was based on reducing cases, wastewater surveillance detections, hospitalisations and deaths due to COVID-19, and in the context of high vaccination rates,

widened access to antivirals, and continued access to free rapid antigen tests (RATs) and masks.

As at the week ending 07 October 2022, COVID-19 case counts started to increase slightly, albeit from a low base, while hospitalisation trends and levels of viral particles in wastewater remain relatively stable. Modelling shows a slow rise sustained through the end of the year, based on waning immunity. Additionally, there are several subvariants circulating domestically and internationally that appear to have a growth advantage over our predominant BA.5 variant.

However, the actual trajectory and severity of future outbreaks remains uncertain due the inherent challenges of modelling based on imperfect information regarding immunity levels, the impact of policy changes and population behaviour. As the COVID-19 pandemic continues to evolve, the legal orders that give effect to the Government's COVID-19 response have been under active review to ensure they provide an effective public health response, and to ensure that the measures remain proportionate in terms of the Bill of Rights Act.

Following the repeal of the COVID-19 Protection Framework by Cabinet and the shift to a new strategy for managing COVID-19 [CAB-22-MIN-0380], the new approach provides increased flexibility that can respond to new variants of concern as they emerge, while also providing the flexibility to manage with lower case numbers if they continue to decrease. To give effect to the new strategy, Cabinet agreed that an approach of relying on baseline measures will be used, with more restrictive reserve measures used as guided by public health advice.

Baseline measures will cumulatively help to ensure the burden on the health system is minimised, our communities are strengthened, and those who feel vulnerable feel safe and are less at risk of infection or poor outcomes from COVID-19. These measures largely move away from mandatory requirements, and instead rely on voluntary uptake, increasing the overall stability of our response as they are not subject to ongoing changes to the legislative framework. Baseline measures can be in place at any time and be scaled as required. Examples include maximising population immunity through vaccination, investment in the healthcare system, anti-viral therapeutics, and surveillance testing. These measures may be here to stay as part of our long-term management of COVID-19.

Most reserve measures are rights limiting. They rely on powers triggered in particular circumstances (e.g., an epidemic notice) and involve a more acute trade-off between limiting transmission, economic impacts and impacts on people's rights. These measures would be used if proportionate to do so, guided by public health advice. These may include vaccination requirements, mask requirements, gathering limits, movement restrictions, and border measures.

The current use of reserve measures was considered as part of the Public Health Risk Assessment process, which has been the standard process for providing public health advice to manage the ongoing pandemic. The Public Health Risk Assessment is a formal discussion involving public health, clinical and scientific expertise that draws on detailed data, evidence and provides a robust process for consideration of public health changes at pace.

This Regulatory Impact Statement reviews the proposals from the Public Health Risk Assessment, particularly in terms of the proportionality under the Bill of Rights Act, equity and Te Tiriti o Waitangi implications, as well as the broader impact of the proposals.

What is the policy problem or opportunity?

What is the nature, scope, and scale of the problem?

The Ministry of Health has reviewed the legislative framework in the Orders that sit under the COVID-19 Public Health Response Act 2020 for the ongoing management of the public health response. This is to ensure the response remains effective, justifiable and proportionate under the Bill of Rights Act 1990.

In particular, the measures that were considered are:

1. the requirement to provide information by air arrivals for COVID-19 contact tracing
2. the 7-day case isolation requirement
3. point of care tests regulation
4. the current masking requirements in healthcare settings.

It is important to note that these measures do not operate in isolation. They are supported by a number of "baseline" measures that do not require Orders (and by extension are not the directly in the scope of this document). Specifically:

- s9(2)(f)(iv) [redacted]
- Access to vaccination.
- Access to antiviral medications (for those at risk of serious illness).
- Availability of free masks and rapid antigen tests for the general public.
- Availability of free N95 type masks for people at high risk of severe outcomes.

The measures considered were reviewed in the context of the current and likely short term COVID-19 risk, therefore the scope of options considered:

- includes the status quo and stepping down alternatives, in light of the ongoing reduction in the COVID-19 risk
- implicitly, but not directly, assesses the consistency of the proposed changes to COVID-19 policy settings with the Variants of Concern Strategic Framework (published 23 June 2022).[1]

Who are the stakeholders in this issue, what is the nature of their interest, and how are they affected? Outline which stakeholders share your view of the problem, which do not, and why. Have their views changed your understanding of the problem?

The ongoing response to COVID-19 effects everyone in Aotearoa New Zealand, however certain groups are more at risk due to clinical or equity-based reasons (and this is explored below). The response also requires ongoing support from business and communities to ensure the public health response remains effective.

[1] https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-response-planning/variants-concern-framework-summary

In seeking to remain proportionate, we continue to balance public health risk against the need to minimise any compulsory measures and any associated impost.

DPMC has carried out engagement based on draft public health advice with the Strategic Public Health Advisory Group, representatives from nine disability groups, members of the National Iwi Chairs Forum (NICF) and the Regional Leadership Groups (RLGs).

The Strategic Public Health Advisory Group discussed the limitations of using personal experience to understand compliance or the effectiveness of public health measures, and emphasized the importance of social science to understand community attitudes. They also noted that their highest risk patients regularly visit pharmacies, in relation to mask requirements. Members also noted the value of considering COVID-19 in the context of other respiratory illnesses generally, rather than in isolation.

The NICF supports retaining self-isolation for cases, while expressing concerns with regards to the reach and communication of support surrounding self-isolation, with COVID-19 cases potentially questioning their eligibility.

Regional Leadership Groups (RLGs) are 12 regional groups across the country comprising community leaders such as iwi, local govt (Mayors and/or Council chief executives), other community leaders eg Chamber of Commerce chief executives. RLGs consist of iwi, local government and community leaders' who provide a regional voice on COVID-19 issues. Regional Public Service Commissioners and other regional public service leaders attend this group to collaborate and coordinate on regional priorities.

RLGs had mixed views on retaining or removing government mask mandates. While many supported a precautionary approach, particularly in healthcare settings where immunocompromised people attend, it was noted that businesses and services should make decisions on mask use that are appropriate to their circumstances. There was support for masks and mask guidance continuing to be made readily available

RLGs also had mixed views on retaining or reducing case isolation. A majority supported test-to-release case isolation or retaining seven days, as this was thought to protect the health system and the health and welfare of people, particularly elderly people who may not be recovering as quickly as the general population. Some RLGs pointed out that retaining some isolation would avoid needing to stand up isolation again in the near future. However, compliance with case isolation was questioned with some RLGs noting low compliance among cases that have important events to attend, pressure from employers, and financial concerns. A small proportion was supportive of treating COVID-19 like any other virus and therefore removing isolation requirements all together.

Public Health Risk Assessment consultation

In September 2022, feedback was sought from stakeholders representing groups at greater risk to the effects of COVID-19 (Pacific Peoples, Māori and Disabled Peoples). Stakeholder engagement was undertaken to inform the Public PHRA held 03 October 2022. Stakeholders included approximately 50 individuals representing the following sectors: NGOs, Tertiary Education Institutes, Health Professionals, Community Groups, Health Service Providers and subject matter experts within government agencies.

Across the board there was strong support for retaining the current mandated measures to protect vulnerable communities. The move away from the Elimination Strategy and removal of other mandatory requirements were considered to put Pacific, Māori and Disabled communities at greater risk.

Generally, these stakeholders expressed concern that if restrictions were removed, the community at large may not take the risk of COVID-19 seriously and put vulnerable populations at greater risk.

Does this problem disproportionately affect any population groups? eg, Māori (as individuals, iwi, hapū, and whānau), children, seniors, people with disabilities, women, people who are gender diverse, Pacific peoples, veterans, rural communities, ethnic communities, etc.

Across the health system, Māori and Pacific peoples are more at risk of negative health outcomes than non-Māori non-Pacific Peoples of the same age, and are also more likely to experience greater disease exposure. Similarly, those experiencing socio-economic disadvantage are at greater risk of severe negative health outcomes than affluent people of the same age, and are also more likely to experience greater disease exposure.[2]

COVID-19 is no exception to these disparities. The burden of COVID-19 does not fall equally, and some people are at higher risk of adverse health outcomes from the virus.

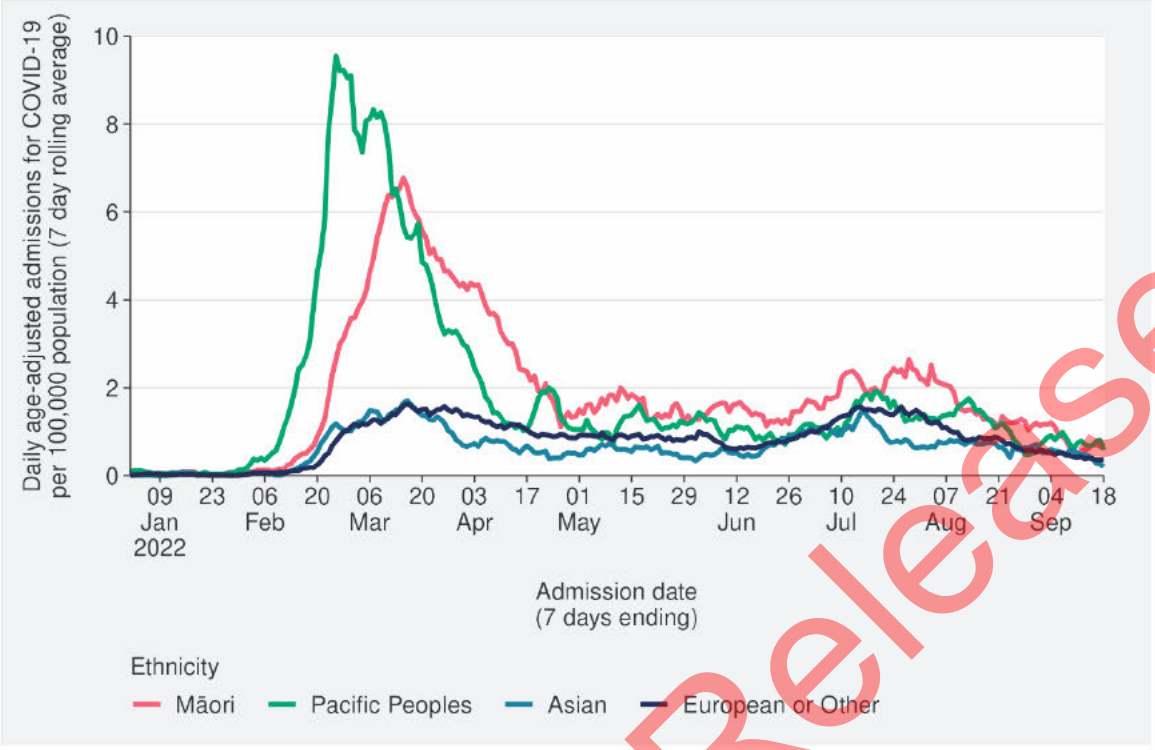
Hospitalisation rates

Analysis undertaken to assess hospitalisation risk from COVID-19 has found that disparities in hospitalisation risk by ethnicity, deprivation and vaccination are clearly observed after adjusting (age-standardising) for differences in age demographics.

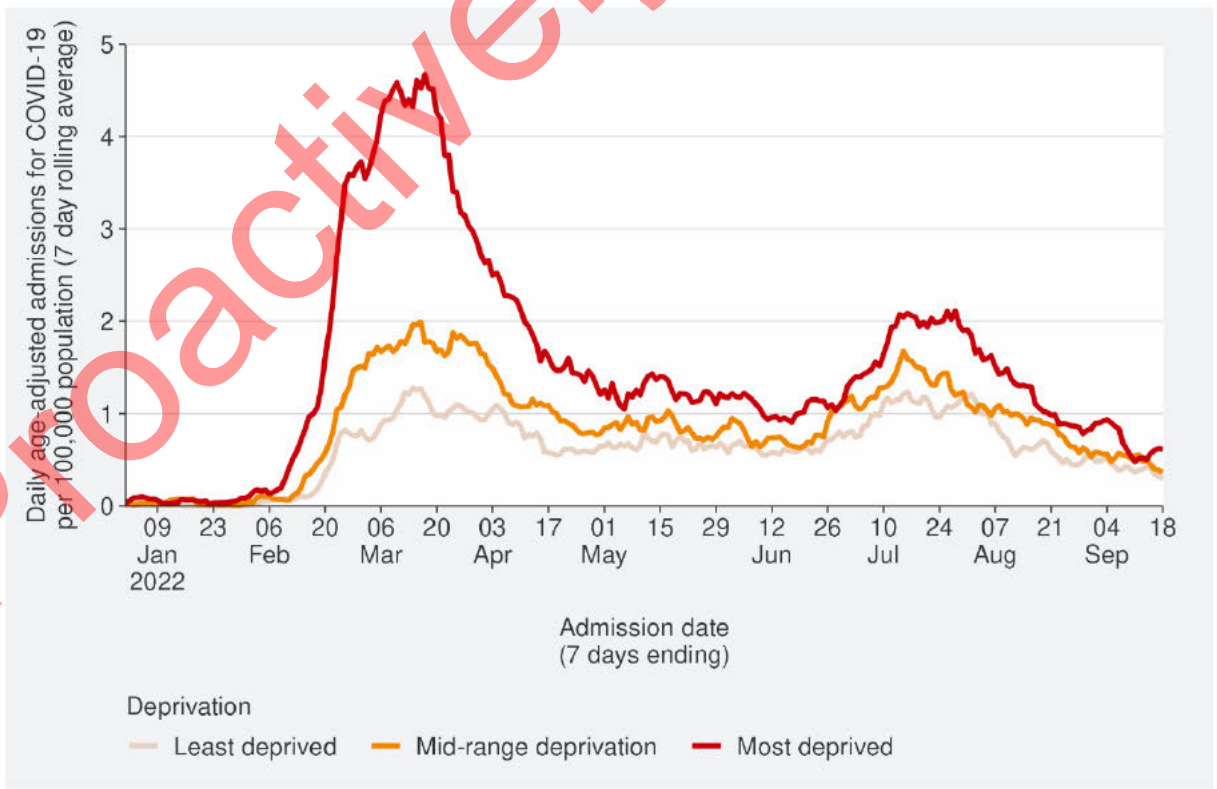
The age-standardised Māori cumulative hospitalisation rate for COVID-19 is 2.1 times higher than European or Other. Pacific Peoples had the highest cumulative incidence rate of hospitalisation with COVID-19, which was 2.8 European or Other ethnicity. (see Figure 3 below).

[2] These statements are supported by the *Health System Indicators framework: Measuring how well the health and disability system serves New Zealanders* last updated 15/06/2022,

Figure 3 - Age-standardised cumulative incidence of hospitalisation with COVID-19 by ethnicity, January 2022 to 18 September 2022



Similarly, those most deprived communities have had, and continue to have, the highest rates of hospitalisation, both recently and cumulatively during 2022. Those most deprived communities have had 2.1 times the risk of hospitalisation compared with those who are least deprived.



Mortality rates

As at 9 October, there were 2,055 deaths attributed to COVID-19 in 2022. The weekly number of deaths attributed to COVID-19 has continued to decrease.

The age-standardised cumulative mortality rate for Māori is 2.0 times higher than European or Other. Pacific Peoples have the highest age-standardised cumulative mortality risk of any ethnicity, 2.5 times that of European or other ethnicities.

Targeted protections to address disparities

That is why the baseline measures include targeted protections for the most vulnerable. For example, in the winter package there was expanded access to antivirals, particularly for people at significant risk of adverse health outcomes from COVID-19. These measures included increased availability of medical masks, including to Pacific churches, marae, kaumatua facilities, aged residential care (ARC), and Māori and Pacific vaccination providers.

Increases in the risk of health impacts of COVID-19 could disproportionately affect populations groups such as older people, disabled people, Māori, Pacific peoples, and some ethnic communities.

We have provided more detailed equity analysis in the 'analysing the proposals' section.

Are there any special factors involved in the problem? e.g, obligations in relation to Te Tiriti o Waitangi, human rights issues, constitutional issues, etc.

Given the broad implications of COVID-19 requirements and consistent with the requirements in the COVID-19 Public Health Response Act 2020, we need to consider Public Health Implications, Bill of Rights Act Implications and Te Tiriti o Waitangi and Equity Implications.

Public Health advice:

These proposals are informed by the Public Health Risk Assessment process, and the summary findings from the PHRA are noted in the analysis. The intention in this RIS is not to review the public health analysis, but to consider the other factors that inform the regulatory process.

Bill of Rights Act and other legal implications:

s9(2)(h)

Te Tiriti o Waitangi, and ensuring proposals uphold the following principles:

- Tino rangatiratanga
- Equity
- Active protection
- Options
- Partnership.

Te Tiriti o Waitangi implications and equity implications have been assessed in the 'analysing the proposals' section.

Outline the key assumptions underlying your understanding of the problem.

The overarching issues that have prompted this problem are:

- Changing public health context, where the risk from COVID-19 has reduced at the current time (although we need to remain prepared for future variants of concern).
- Bill of Rights Implications, noting that with the changing public health context and the length of time the measures have been in place, proportionality continues to evolve.
- Following the repeal of the COVID-19 Protection Framework, the current strategic approach is more flexible and better suited to the current context.

What objectives are sought in relation to the policy problem?

We are seeking a response that is consistent with the overall objectives of the strategic approach, and fulfils key health objectives.

The overall objectives are:

- **Prepared** means we are prepared to respond to new variants with appropriate measures when required. This includes having the measures in place, including surveillance, to know when and how we might need to respond.
- **Protective and resilient** means we continue to build resilience into the system, and continue both population and targeted protective measures. We take measures as part of our baseline that reduce the impact on individuals, families, whānau, communities, businesses, and the healthcare system that will make us more resilient to further waves of COVID-19.
- **Stable** means our default approach is to use as few rights and economy limiting measures as possible. As part of our baseline there are no broad-based legal restrictions on people or business, and no fluctuating levels of response to adapt to.

Section 2: Deciding upon an option to address the policy problem

What criteria will be used to compare options to the status quo?

Consistent with the requirements in the COVID-19 Public Health Response Act 2020, and other related requirements, we have identified the following criteria.

Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds Bill of Rights Act 1990 (BORA) considerations (thereby informing the legal basis for the measures considered).

Economic and social impact- evidence of the effects of the measures on the economy and society more broadly

Equity- Evidence of the impacts of the measures for at risk populations

Compliance- expected public compliance with measures (noting that this would only be used where compliance is relevant- e.g not where there is a mandated requirement to fulfil e.g vaccination for health care workers, or information provision from new arrivals).

These criteria are the aligned to the criteria for the new strategic approach. We note that implementation considerations are being considered separately, in Section 3 below.

What scope will options be considered within?

This is focussed on the reviewing the public health responses to COVID-19 that require COVID-19 specific Orders, as listed in the problem statement.

Analysing the proposals

You will find the proposals for different options for each of the measures considered below. This is then supported by analysis, including public health advice and multi-criteria assessment.

The key for the multi-criteria assessment is as follows:

Key for qualitative judgements:	
+	better than doing nothing/the status quo/counterfactual
+/-	about the same as doing nothing/the status quo/counterfactual
-	worse than doing nothing/the status quo/counterfactual

1. Provision of information by air arrivals for COVID-19 contact tracing

Options

Option 1: Status-quo – mandatory collection through NZTD	Option 2: No mandatory collection through NZTD
Retain the current mandatory requirement, under the COVID-19 Public Health Response (Air Border) Order 2021, for arrivals to New Zealand to provide contact details and travel history information to assist potential future contact tracing.	Remove the requirement and, if and when necessary, stand-up digital collection through NZTD and in the interim use scanned paper information.

Public Health Risk Assessment recommendation

PHRA recommendation	Remove the requirement on the basis that it is no longer proportionate in the current phase of the pandemic: • it is unlikely that contact tracing will be effective in responding to the most likely next serious variant of concern (high transmissibility and low severity) • if contact tracing were required, digital collection through NZTD could be stood up again if and when necessary.

Multi-criteria assessment

Criteria	Option 1: Status quo – mandatory collection through NZTD	Option 2: No mandatory collection through NZTD

Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds BORA considerations	+/- • This mandatory measure was seen as proportionate earlier in the pandemic on the basis that it involved a minor imposition on people returning to New Zealand, relative to the benefit of enabling more timely contact tracing in the event of a new variant of concern.	+ In the current situation: • Contact tracing is likely to be of limited value in response to a serious new variant of concern given the absence of other restrictive measures. • Scenario planning has determined that contact tracing will not be effective in the context of a new variant of concern.
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- Costs include: • for travellers, the time and inconvenience cost for them (pre-flight, or post-arrival) in providing some information twice (on the arrival card and through NZTD). • for border staff, the costs include the impacts of delays in processing flights when the paper form of NZTD must be completed by passengers on arrival.	+ While difficult to estimate, the reduced costs are estimated at: • for travellers the reduction in costs might be of the order of $2.8 million per month (on the basis of 12,000 travellers per day, 20 minutes to complete declaration, and an opportunity cost of traveller time at $25/hour). • reduced government expenditure on this measure.
Equity- Evidence of the impacts of the measures for at risk populations	+/- The equity impact of the measure can be considered in relation to: • immediate impacts of collecting the information - depending on relative disadvantage in respect of internet access or language challenges, they may be inequitably affected by this measure (time	+/- • If the measure were removed, the equity impact on at-risk populations could be neutral or very slightly positive. To the extent that at-risk populations have a relative disadvantage in respect of internet access or language challenges, they may be inequitably affected by this measure (time completing NZTD; need to do paper NZTD on arrival).

	completing NZTD; need to do paper NZTD on arrival). • potential future benefits from the use of the information – contact tracing is likely to only have limited effectiveness in the context of a new variant of concern.	
Compliance- expected public compliance with measures	+/- • Under this option to date a high level of overall compliance (digital or paper completion) with NZTD has been achieved (at least 90% digital).	+ • Under this option, there is no NZTD requirement travellers must comply with. Not imposing additional or unnecessary compliance costs on travellers now may help to maintain social licence that is likely important if future restrictions or requirements need to be imposed at the border.
Overall	+/-	+ • The mandatory collection of information through NZTD is no longer proportionate from a public health perspective. Contact tracing in isolation is unlikely to be an effective measure in responding to the most likely serious new variants. • However, there are non-health related reasons for maintain the NZTD. As such, the NZTD will (from 5 November) be enabled by rules under section 421(1) of the Customs and Excise Act 2018 for wider border purposes. If contact tracing of air passengers arrivals for COVID-19 is desired in future, passenger information could be

		accessed from the NZ Customs Service under provisions in the Health Act 1956

The 7-day case isolation requirement

Counter-factual and proposal

Option 1	Option 2
Status quo: the 7-day case isolation requirement remains in place to support the ongoing effective isolation of cases, to prevent spreading COVID-19 outside the household.	Remove mandatory 7-day self-isolation for cases and replace with guidance

Public Health Risk Assessment

PHRA recommendation	Maintain the current 7-day COVID-19 case isolation requirement, at this time. Isolation of infectious cases to reduce community transmission remains an important way to suppress transmission of COVID-19 and subsequently higher numbers of cases, hospitalisations, and deaths. It is likely that the increase in community cases would affect some communities and population groups more than others. Strong concern was expressed that if the isolation mandate was removed, it would have disproportionate impacts for Māori and Pacific communities.

Multi-criteria assessment

Criteria	Option 1: (Status quo) retain 7-day self-isolation requirements for cases	Option 2: removing mandatory self-isolation for cases
Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds BORA considerations	+/- • Isolation of infectious cases to reduce community transmission remains an important way to suppress transmission of COVID-19, and prevent prolonging the current outbreak. • s9(2)(h) [redacted]	- • This approach for cases is likely to lead to subsequently higher numbers of cases, hospitalisations, and deaths and potentially a more pro-longed outbreak. • s9(2)(h) [redacted]

	s9(2)(h) [redacted]	s9(2)(h) [redacted]
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- • The ongoing use of self-isolation is likely to maintain current levels of self-isolation days, however if this is removed it would need to be traded off against the negative health impacts. • The economic impact of CPF Orange was estimated at 1%-2% of GDP in aggregate, $105m per week, with the most significant impact being from self-isolation. • There are wider impacts that are felt across education, health, and other critical services, and on wider society. It's important to note that these impacts will decrease as overall case numbers decrease.	
Equity- Evidence of the impacts of the measures for at risk populations	+/- • Maintaining these requirements reduces potential cases, hospitalisations and deaths, particularly for communities who are at greater risk.	- • s9(2)(g)(i) [redacted] . s9(2)(f)(iv) [redacted] • Coercion to return to work particularly for the most vulnerable. Strong concern was expressed that if the isolation mandate was removed, employees may be pressured to return to work even if not fully recovered.
Compliance- expected public compliance with measures	+/- • While it remains a requirement, compliance is likely to be higher.	- • Moving away from a compulsory requirement is likely to decrease the level of compliance. • Accurate domestic data on the behavioural impact of shifting from mandatory isolation to

		guidance is lacking. However, data from the UK infection survey (based on adherence rates to guidance in the UK) suggests potentially larger increases in cases and hospitalisations from such a change.
Overall	+/- • Given the potential public health impacts, this remains effective, justifiable and proportionate at this time. It will be critical that this remains under regular review.	- • Moving away from this approach at this time is likely to increase the public health risk and resulting impacts.

Point of care testing

Counter-factual and proposal

Option 1	Option 2
Status quo: retain the current framework (regulating the importation, manufacture, supply, sale, packaging or use of point of care tests by Order)	Remove the current framework but rely on baseline (non-COVID-19 specific) regulation, guidance and government procurement

Public Health Risk Assessment

PHRA recommendation	It is appropriate to maintain the regulation of point of care testing, so long as mandatory self-isolation requirements remain in place.

Multi-criteria assessment

Criteria	Option 1: (Status quo) retain the current framework	Option 2: removing the current framework
Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds BORA considerations	+/- • The results obtained from POCTs inform COVID-19 policy and response measures. Ensuring devices can detect the virus, especially as variants evolve, helps to ensure that our system-wide response to COVID-19 is appropriate	- • Under this option, there would be no prohibition on the dealing, importation, manufacture, or use of point of care tests. Only government-distributed and procured devices would undergo a formal approvals process. • This could result in less-reliable and less-accurate devices being available on the market
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- • As with the removal of any regulatory process, some commercial parties may perceive inequities of having borne compliance costs in seeking approvals where that is no longer required for new market entrants. There may also be a perception from the public that the previously strict approvals process was a burden that was ultimately not required	
Equity- Evidence of the impacts of the measures for at risk populations	+/- • The purpose of this Order is to ensure that point of care tests that are relied upon to establish whether a person is subject to mandatory self-isolation requirements are accurate and reliable.	- • Removing this Order could result in more false-positive cases and more false-negatives. The net impact would be increased risk to at risk populations (due to false negatives) and more people being forced to isolate without justification (false positives)
Compliance- expected public compliance with measures	+/-	-

	• People are more likely to use point of care tests if they are perceived as being reliable and accurate.	• Removing this Order could result in less-accurate and less-reliable point of care test being on the market. People are therefore less likely to be compliant.
Overall	+/- • Point of care tests remain the dominant form of COVID-19 testing in New Zealand by a substantial margin. Most people who need to test for COVID-19 will do so first through a point of care test. It is therefore desirable that the Government has a proactive involvement in ensuring these devices are safe and reliable.	- • Moving away from this approach at this time is likely to increase the public health risk and resulting impacts.

Mask settings

Options

Option 1 (PHRA Proposal)	Option 2
Retain current mask requirements in healthcare settings (including aged residential care)	Remove the mask requirement and provide guidance to health services to set masks policies

Public Health Risk Assessment

PHRA recommendation	Retain the current requirement mask requirements. While adherence to mask requirements may be waning or patchy in some health service settings, it is possible that adherence would drop further if the mandate was removed. Mask requirements lean against inequity, to ensure that people who are at higher risk can access health services without avoidable additional risk. Removing mask mandates in health service settings may lead to an increase in cases of hospital-acquired COVID-19.

Multi-criteria analysis

Criteria	Option 1 (status quo): Mask requirements in healthcare settings	Option 2: Remove the mask requirement and provide guidance to health services
Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds BORA considerations	o • s9(2)(h) [redacted]	+ • s9(2)(h) [redacted]
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- • Aggregate economic impact of stepping down mask mandates relative to the status quo is relatively small, particularly as guidance will be communicated and some level of compliance is retained.	
Equity- Evidence of the impacts of the measures for at risk populations	o • Current mask use provides effective protection for vulnerable populations.	+/- • Relative to the status quo, notwithstanding the uncertainty around compliance, the intent is for masks to be mandated in relatively similar

		settings, with the objective of protecting at risk populations.
Compliance- expected public compliance with measures	o • While there were challenges with the introduction of the masks requirement, the principle of "stability" suggests retaining the current approach now it is established. • Changes would require communications to health services in implementing masks policies.	+/- • Challenges have been experienced – both in terms of communications and operationally – to implement the status quo through a single mechanism for requiring masks for staff and patients, and another mechanism for visitors. • A key success criterion for this option will be communicating the policy clearly.
Overall	o	+

Equity analysis

The burden of COVID-19 does not fall equally, and some people are at higher risk of adverse health outcomes from the virus. Priority populations such as Māori, Pacific peoples, older people, disabled people and tāngata whaikaha Māori, and some ethnic communities experience disproportionate impacts of COVID-19 by way of:

- the effects of the virus, for example for those with co-morbidities
- the impact of public health measures on the ability to exercise choice, for example, about carers
- the impact of public health measures on economic stability, for example being unable to afford to take the necessary time of work to isolate or quarantine, or the risk time off creates regarding job security
- the impacts of existing systems relied upon to implement some of the measures in place to manage COVID-19, such as the use of penalties non-compliance with certain COVID-19 Orders and the inability to pay these forging a pathway into the criminal justice system.

Reducing mandated public health measures may lessen the impact of public health measures on choice, economic stability and experience of inequity due to enforcement systems. However, it has the potential to increase the inequity associated with co-morbidities or other health conditions that exacerbate the effect of contracting the virus, for example leading to self-imposed isolation, or an increased chance of hospitalisation or needing medical intervention. Removing measures such as border measures that are not expected to affect the burden on the health system overall may result in the burden being transferred to and disproportionately experienced by priority populations.

An initial assessment of impacts and opportunities of the new strategy for priority populations is set out below.

Due to time constraints, further comprehensive consultation has not been completed with Māori and Pacific Peoples to inform the equity analysis. The new strategy will allow us to be more adaptable and target measures to the most vulnerable communities (e.g., strengthened guidance on testing in highly vulnerable places). It is important that consultation on the proposed changes is carried out to identify the potential impacts on these groups and mitigations. Given that, any stepping down of mandatory measures will need to be accompanied by close monitoring of how the changes impact vulnerable populations.

Equity analysis for Māori

The COVID-19 outbreak has worsened already inequitable health outcomes experienced by Māori. The mandatory measures in place have sought to minimise and protect priority populations from COVID-19. As measures are stepped down, the Manatū Hauora Māori Protection Plan is critical. The plan, due to expire in December 2022, focuses on:

- protecting whānau, hapū, iwi and hapori Māori from the virus by increasing vaccination coverage
- building the resilience of Māori health and disability service providers and Māori whānau, hapū, iwi and hapori Māori to respond to the new environment of the Delta variant, the COVID-19 Protection Framework and the long tail of the impact of COVID-19 on the health and wellbeing of Māori.

For Māori, 86.8 percent of people are at least partially vaccinated and 56.3 percent of Māori eligible for first boosters have received them. While there are high vaccination rates for at least one dose, booster vaccination uptake could be improved among Māori. Particular

consideration of accessibility to tools that prevent risks of transmission or severe disease will be considered for iwi; an example of this is the increased availability of medical masks to marae, kaumatua facilities, and Māori vaccination providers.

Equity analysis for Pacific peoples

Pacific Peoples continue to be disproportionately affected by COVID-19 in addition to long-standing inequitable health outcomes and service use. Recent data shows Pacific Peoples are the demographic most hospitalised for COVID-19 and their COVID-19 mortality rate is four times greater than European or other ethnicities.

91.7 percent of Pacific peoples are at least partially vaccinated (compared to 91.5 percent across all ethnicities) and 61.2 percent of eligible Pacific peoples have received at least one booster dose (compared to 73.1 percent across all ethnicities). There is more work to be done in encouraging booster vaccination uptake among Pacific peoples to mitigate the impact of removing mandatory measures.

Equity analysis for older people

Older people are more likely to be hospitalised and this is reflected in the latest data. As the virus takes longer to move through this population due to this group having fewer social interactions, it may lead to a higher hospitalisation burden over a longer period beyond winter. Removing mask requirements will have an impact amongst this group.

Equity analysis for disabled people and tāngata whaikaha Māori

The Human Rights Commission's report Inquiry into the Support of Disabled People and Whanau during Omicron found that lessening restrictions led some disabled people to choose to isolate themselves, leading to feelings of isolation and stress and a restriction on their own freedoms for the benefits of others. The continuation of measures, particularly face masks when accessing essential services, creates reassurance. Changes to these requirements in the future are likely to cause greater anxiety and risk for disabled people, particularly those with underlying co-morbidities.

Without data disaggregated by disability, determining impacts of variants of concern or public health measures on disabled people and tāngata whaikaha Māori would be difficult.

Equity analysis for other groups

Those who live in crowded housing, especially Māori, Pacific peoples, and some ethnic communities for example, living in an intergenerational arrangement, or those who work in particular roles such as hospitality or retail, are also likely to be more at risk of transmission.

Removing the requirement for household contacts to self-isolate would reduce disruption in the education sector for children, young people, and education workers, and enable tertiary education providers to continue delivering services which have been challenged by staff shortages. More learners will be able to access in-person learning.

Te Tiriti analysis

Demonstrating a commitment to and embedding the Te Tiriti and achieving Māori health equity remain a key COVID-19 health response priority. The COVID-19 outbreak has worsened the already inequitable health outcomes for Māori.

In December 2021, the Waitangi Tribunal's Haumaru: COVID-19 Priority Report found that the Government's rapid transition into the CPF breached Te Tiriti principles of active protection, equity, tino rangatiratanga, partnership and options. The Crown would remain in active breach

until the Waitangi Tribunal recommendations were addressed or if a similar rapid shift from the CPF's mandated measures occur.

Following the revocation of the CPF and the changes proposed following the latest PHRA, the Māori Protection Plan's two key drivers are critical. Related response initiatives should continue to have a positive impact for Māori, including the ongoing Winter Package measures. This includes as free medical and N95 masks, greater access to antivirals for those that are eligible by prioritising equitable access for Māori alongside other eligibility criteria, and COVID-19 and flu vaccinations. However, a future PHRA may need to further consider measures to assist Māori if infection rates and hospitalisations do not improve in the interim.

In DPMC's discussions with NICF members about stepping down mandatory measures, they were concerned about tino rangatiratanga, particularly over marae – i.e., marae should be empowered to manage the welfare of their people rather than having requirements externally mandated. The suggestion was to replace it with accessible guidance on best practice and continued communications to address the complacency and misinformation some NICF members are observing. NICF members have also observed the hardship that requiring household contacts to isolate placed on many whānau, and that there will be some support for the removal of this requirement.

Measures targeted at Māori continue to be necessary but have not been sufficient alone to create equitable health outcomes for Māori. We need to identify targeted measures and public health levers that will enable the Crown to meet its obligations under Te Tiriti o Waitangi and help reduce inequities in COVID-19 effects. The work of Te Aka Whai Ora with Kaupapa Māori providers is particularly key to realising this duty. NICF members and disability sector representatives reinforced the value of Kaupapa Māori providers in reducing inequities as they provided holistic support for whānau and had deeper reach than other providers.

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

Based on an overall assessment, the recommendations are to

a. remove the requirement to provide information by air arrivals for COVID-19 contact tracing
b. retain mandatory self-isolation of cases
c. retain point of care tests regulation
d. remove and replace masks requirements in healthcare settings (including aged residential care) with guidance for health services to set masks policies.

Section 3: Delivering an option

How will the new arrangements be implemented?

The proposals in this paper require amendments to Orders made under the Act. Specifically:

- Revoking the Air Border Order – as the mandatory collection of traveller information through NZTD is the last remaining substantive health requirement in the COVID-19 Public Health Response (Air Border) Order 2021, the Order should now be revoked. The timing of revocation should allow for any operational implementation considerations.
- If the Government decides to move to guidance for health services to set masks policies, then the COVID-19 Public Health Response (Masks) Order 2022 can also be revoked.

There are no changes proposed to the remaining Orders under the Act, being the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022; and the COVID-19 Public Health Response (Point-of-care Tests) Order 2021.

Further consultation will be completed on the self-isolation proposals, particularly with priority population groups to understand their perspectives.

For the most part, where further measures are required to support ongoing adherence to public health advice or where additional surveillance is required, this is already in place. Work is progressing on the development of communications for new arrivals, and the additional surveillance required is already in place.

Clear communications on these changes will be supported, including through the use of the Unite Against COVID-19 channels, targeted information campaigns, and by supporting announcements on these changes.

Planning for new variants of concern has been prepared through the COVID-19 Variants of Concern Strategic Framework. Work is currently well advanced with DPMC and other agencies to ensure that we have the legal framework, and we are operationally prepared to respond as needed in the future. Any future changes would be subject to further Public Health Risk Assessments.

How will the new arrangements be monitored, evaluated, and reviewed?

The public health measures will remain under regular monitoring and review, this includes monitoring of case numbers, hospitalisations, international trends to identify variants of concern, along with wastewater and other surveillance activities. Trends in case numbers, hospitalisations and mortalities are compared by ethnicity and deprivation. The results of this monitoring and surveillance is compiled into a weekly insights report (as well as other ad hoc reporting) to help inform decision making.

s9(2)(f)(iv) [redacted]

Development is underway of both a COVID-19 infection prevalence survey and a COVID-19 seroprevalence survey. The surveys provide an opportunity to establish a national active surveillance initiative within New Zealand, gathering useful evidence to support short- and medium-term pandemic management and planning, and with potential to be adapted for other public health surveillance requirements in the future.

Cabinet

Minute of Decision

October 2022 Review of Remaining COVID-19 Measures Under the New Approach

Portfolio **COVID-19 Response**

On 17 October 2022, Cabinet:

1 Background

2 **noted** that in September 2022, because of the declining COVID-19 risk, the government moved to a new more stable approach to managing the virus, based on baseline and reserve measures [CAB-22-MIN-0380];

3 **noted** that on 12 September 2022, Cabinet agreed to:

3.1 remove COVID-19 border vaccination requirements, post-arrival COVID-19 testing requirements (replaced with guidance for air arrivals to test on days 0/1 and 5/6), and requirements not to exhibit COVID-19 symptoms or be under a public health direction for arrivals;

3.2 remove all remaining COVID-19 vaccination mandates;

3.3 remove mandatory self-isolation of household contacts, to be replaced with guidance only to test daily for five days;

3.4 retain mandatory self-isolation of cases for seven days;

3.5 retain requirements for air travellers to provide information for COVID-19 contact tracing purposes prior to departure;

3.6 retain government mandated masks for visitors to healthcare services, including primary care, urgent care, hospitals, aged residential care and disability-related residential care, but excluding counselling, mental health and addiction services;

4 [CAB-22-MIN-0380]

5 **noted** that the Director-General of Health has provided advice to the Prime Minister and other relevant Ministers on the renewal of the Epidemic Preparedness (COVID-19) Notice 2022 (the epidemic notice), and has recommended letting it expire at 12:01am on 20 October 2022;

6 s9(2)(h) [redacted]

Review of case isolation requirements

7 **agreed** for self-isolation of cases, on the basis that the legal basis has been confirmed, to retain the status quo of seven-day mandatory self-isolation;

8 **noted** that the Director-General of Health has recommended retaining the current guidance for household contacts to test daily for five days;

Review of government-mandated mask requirements

9 **agreed** for masks, on the basis that the legal basis has been confirmed, to retain government-mandated mask requirements for visitors to healthcare services;

Provision of information for contact tracing for air arrivals

10 **noted** that the New Zealand Traveller Declaration (NZTD) will replace the paper arrival card from mid-2023 following legislation to be introduced in November 2022, and that passenger contact tracing could be enabled if required by Public Health advice.

11 **agreed** to remove requirements for air arrivals to provide contact information for COVID-19 contact tracing purposes from the COVID-19 Public Health Response (Air Border) Order 2021 (the Air Border Order), as recommended by the Director-General of Health;

Post-arrival testing

12 **agreed**, for post-arrival testing, to update guidance so that only symptomatic air arrivals are recommended to test and, if positive within a week of arrival, to get a PCR test, as recommended by the Director-General of Health;

13 **noted** that, in the event of a variant of concern with high clinical severity and high immune evasion, the disruption caused by COVID-19 may justify an epidemic notice, enabling the use of COVID-19 orders and emergency powers under other legislation;

14 s9(2)(f)(iv) [redacted]

Support schemes

15 s9(2)(g)(i) [redacted]

16 **agreed** that further decisions regarding eligibility for Care in the Community support and associated funding be delegated to the Minister of Finance and the Minister for Social Development and Employment;

Next steps

17 **noted** that, to give effect to the above decisions, the Minister for COVID-19 Response will retain:

17.1 the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022;

17.2 the COVID-19 Public Health Response (Masks) Order 2022;

17.3 the COVID-19 Public Health Response (Point-of-care Tests) Order 2021;

18 **noted** that, to give effect to the above decisions, the Minister for COVID-19 Response will revoke the COVID-19 Public Health Response (Air Border) Order 2021;

19 **noted** that any remaining government-mandated measures will be reviewed in late November 2022;

20 **directed** the Ministry of Health, in consultation with Te Whatu Ora and the Department of the Prime Minister and Cabinet, to provide updated advice to Ministers early in 2023 on planning for winter 2023, including advice on the further use of vaccinations/boosters;

21 s9(2)(f)(iv) [redacted]

Rachel Hayward
Acting Secretary of the Cabinet