Proactive Release

The following documents have been proactively released by the Department of the Prime Minister and Cabinet (DPMC), on behalf of the Minister for COVID-19 Response, Hon Dr Ayesha Verrall:

Future of the COVID-19 Protection Framework and Moving to the New Approach

The following documents have been included in this release:

Title of paper: Future of the COVID-19 Protection Framework and Moving to the New Approach (SWC-22-SUB-0159 refers)

Title of paper: Regulatory Impact Statement: Review of Public Health Measures to support the future of the COVID-19 Protection Framework and moving to the new strategy

Title of minute: Future of the COVID-19 Protection Framework and Moving to the New Approach (SWC-22-MIN-0159 refers)

Title of minute: Future of the COVID-19 Protection Framework and Moving to the New Approach (CAB-22-MIN-0365 refers)

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)(h), to maintain legal professional privilege; and
- section 9(2)(j), to enable negotiations to be carried on without prejudice or disadvantage.

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Office of the Minister for COVID-19 Response

Cabinet Social Wellbeing Committee

Future of the COVID-19 Protection Framework and moving to the new approach

Proposal

1 This paper reports back to Cabinet on recommended timing to move to the new COVID-19 baseline and reserve approach and repealing the COVID-19 Protection Framework. It also lists the public health measures that I propose will be in place as we move to the new approach.

Relation to Government priorities

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

Executive Summary

3 Throughout the pandemic, our strategy has evolved in line with the COVID-19 public health context. While we successfully implemented both the elimination strategy and the minimise and protect strategy, the environment is very different now to what it was when these strategies were conceived. Changes in the COVID-19 virus, our protections against it, and in public compliance and sentiment continue to require us to adapt our approach.

4 In June 2022 we agreed to shift from the COVID-19 Protection Framework (CPF) to a new approach for managing COVID-19 [SWC-22-MIN-0118] with the timing to be confirmed in a report-back to Cabinet in August 2022. The new strategy – our long-term approach to managing COVID-19, is based on baseline and reserve measures where baseline measures will provide stability and reserve measures will ensure we are prepared for future risks.

5 This long-term approach to managing COVID-19 sets us up to move into the future based on the most likely events of the evolution of COVID-19, while remaining prepared for variant outcomes and building resilience across the system. We will move towards managing COVID-19 like other infectious illnesses in the medium to long term and away from the use of extraordinary powers.

6 New Zealand's current COVID-19 outbreak is waning, with reducing case numbers, hospitalisations, and deaths. COVID-19 Modelling Aotearoa (CMA) modelling suggests this trend should continue into September.

7 The most likely medium-term COVID-19 outlook for New Zealand suggests waves of COVID-19 infection and reinfection, as seen internationally. The severity of future outbreaks remains uncertain and so we must remain ready to respond with reserve

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measures. Should a new variant of concern be identified that justifies the use of significant reserve measures (e.g., movement restrictions), these can be quickly implemented to respond to the variant. Most measures can be implemented within 72 hours; some will take several weeks (e.g., managed isolation and quarantine, pre-departure testing, contact tracing).

8 We now have baseline measures in place: we maintain high vaccination rates, good public access to masks and rapid antigen tests (RATs), and improving access to antivirals for those most vulnerable and at risk of becoming very unwell from COVID-19. The Minister of Health and I have also asked officials to review the effectiveness of the package of measures we implemented for winter, so we are better placed to manage COVID-19 alongside other seasonal illnesses next winter.

9 Therefore I recommend that we publicly launch the new approach and repeal the CPF during the week of 12 September 2022.

10 Based on public health advice I propose to remove vaccination requirements and post-arrival testing requirements at the border and the remaining employee vaccination mandates. Guidance for air arrivals to test on arrival on days 0/1 and 5/6 along with other methods (e.g., wastewater testing and targeted surveillance) will continue to provide variant surveillance.

11 I recommend that mandatory seven-day self-isolation for COVID-19 cases is retained, but household contacts will no longer need to self-isolate; instead, they will be asked through guidance to test daily for five days. This approach will be bolstered by a guidance for household contacts to wear a mask while outside their house.

12 I propose that current mask requirements in healthcare settings (including aged residential care (ARC)) are retained. New guidance (superseding current mask guidance) would encourage ongoing mask use as determined by personal factors, that relate to an individual's specific circumstances (such as, individuals who are household contacts), and in specific settings (such as places where there are many vulnerable people). I also propose that masks requirements on public transport are removed and replaced with strong guidance. Retaining mask requirements in healthcare settings is commensurate with the changing risk profile.

13 s9(2)(f)(iv)

Te Whatu Ora is undertaking an extensive programme of work to build health capacity.

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Background

Status of the COVID-19 outbreak and science

15 Cases, wastewater surveillance detections, hospital bed occupation, and fatalities due to COVID-19 are steadily declining from their peak in mid-July and are lower than projected modelling scenarios. As at 29 August, the seven day rolling average for case numbers is 2,431 per day, the lowest since late February. Hospitalisations and fatalities are a lag indicator of cases and are not at the same low-point as cases yet, but modelling suggests that all these metrics should continue to decline into September. Without the emergence of a new variant, CMA modelling suggests that there may be future waves of Omicron late this year, due to waning immunity, but these are likely to be smaller than the most recent wave and work to increase the uptake of third and fourth vaccine doses may reduce the impact of this wave.

16 According to the World Health Organisation, Omicron continues to dominate globally, with the development of multiple second-generation Omicron variants. The BA.5 Omicron sub-variant is dominant, with a range of BA2, BA.4 and BA.5 sub-lineages demonstrating potential to outcompete BA.5. None of the current sub-lineages is expected to cause a 'wave', but the slight growth advantage may continue to contribute to sustained transmission. A variant with a substantial growth advantage and therefore potential to cause a 'wave' is still a possibility. It is therefore important we continue to monitor for new variants. There are fewer isolates being sequenced globally.

17 Manatū Hauora has developed potential scenarios for variants of concern, ranging in their clinical severity and immune evasion. The most concerning scenario (high clinical severity, high immune evasion) is possible, but remains less likely than the other scenarios. Over the short to medium term, the current observed pattern of viral evolution is the appearance of more transmissible variants without a marked change in 'realised' severity, given the layers of immunity in the population. Agencies are reporting to me regularly on their readiness to respond to a new variant.

Background to the new approach

18 Throughout the pandemic our strategy has evolved to respond to changes in the virus, protections we have available, and changes in social license. Initially, the elimination strategy allowed us to keep life as normal as possible in New Zealand while keeping mortality at some of the lowest levels in the world. For the Delta variant we focused on tight suppression to minimise harmful impacts while completing a vaccination campaign. Following very high uptake of vaccinations and reduced clinical severity of Omicron, we shifted to the 'minimise and protect strategy' using the CPF.

19 In June 2022, Cabinet agreed to a new COVID-19 strategy for post-winter and invited me to report back in August to advise whether it is appropriate to revoke the COVID-19 Public Health Response (Protection Framework) Order 2021 (the COVID-19 Protection Framework Order) and move to the new strategy [SWC-22-MIN-0118]. It is intended that this new strategy – our long-term approach to managing COVID-19 - will endure as COVID-19 becomes endemic in New Zealand.

20 As I advised Cabinet in June, our long-term approach to managing COVID-19 needs to set us up to move into the future based on the most likely outcomes of the evolution

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of COVID-19, while remaining prepared for worse outcomes and building resilience across the system. I therefore proposed a new approach to maximise our health, economy, and social wellbeing in the long-term. This includes moving towards managing COVID-19 like other infectious illnesses in the medium to long term and gradually moving away from the use of extraordinary powers.

21 The new approach has the following principles: prepared, protective and resilient, and stable and will replace the minimise and protect strategy currently in place:

21.1. Prepared means we are ready to respond to new variants with appropriate measures when required. This includes having the measures in place, including surveillance to inform a response;

21.2. 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;

21.3. 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 generalised legal restrictions on people or business, and no fluctuating levels of response to adapt to [SWC-22-SUB-0118 refers]. This also includes the retention of mask mandates in certain settings.

22 To give effect to the new approach, Cabinet agreed that an approach of relying on baseline measures will be used, with more restrictive rights-limiting reserve measures used as guided by public health advice.

23 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. With the exception of isolation of cases, these measures largely move away from mandatory requirements, and instead rely on voluntary uptake, increasing the overall stability of our response. They can be in place at any time and be scaled as required. Examples include maximising population immunity through vaccination, investment in the healthcare system, ventilation and surveillance testing. Expanding access to antivirals and increasing their accessibility is a key baseline measures that will help to lessen the impact of COVID-19 in future waves. Baseline measures may be here to stay as part of our long-term management of COVID-19.

24 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, gathering limits, movement restrictions, and border measures. Masks are less rights limiting than other measures.

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COVID-19 measures in place in other countries

25 A recent DPMC insights report looked at requirements in Australia, Denmark, Ireland, the Netherlands, Singapore, and the United Kingdom. The majority of countries analysed have removed COVID-19-related public health mandates and restrictions, shifting to a recommendations approach. However, Australia and Singapore continue to require face coverings and COVID-19 vaccinations for certain occupations or activities.

26 Most of the countries analysed have self-isolation requirements for those testing positive for COVID-19. Isolation timeframes, however, vary based on symptom severity and other factors in the majority countries analysed. The United Kingdom is the only country analysed that recommends, but does not require, those testing positive for COVID-19 to self-isolate.

27 None of the countries analysed require close or household contacts of COVID-19 cases to isolate, though Singapore and Australia continue to require close contacts to test to ensure they do not have COVID-19, and also maintain masking requirements.

Public compliance and attitudes towards existing measures

28 s9(2)(g)(i)

Transitioning to the new approach

29 As the COVID-19 risk and proportionality of mandatory measures wanes, it is now timely to shift away from the CPF. I therefore propose to revoke the COVID-19 Protection Framework Order, and update the other public health measures in place.

30 With the evolution of the COVID-19 outbreak over recent months, the CPF has increasingly posed challenges to providing an effective response. During the recent BA.5 outbreak, public health advice was that a move to the Red setting would not provide a significant impact on cases or hospitalisations to justify the higher restrictions and reducing gather limits to the level where they might be effective would not be proportionate. This resulted in public health advice that the CPF was now of limited utility and should be replaced by the new approach and renewed mask mandates.

31 In July 2022 I announced a package of public health measures (the winter package) to address the rising rates of COVID-19 and other respiratory illnesses. The winter package was comprised of baseline measures included promoting mask use and increasing access to free masks (including for vulnerable communities), widening

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access to therapeutics, increasing access to free RATs, and expanding access to COVID-19 and flu vaccinations. These measures sat alongside existing reserve measures (e.g., mask mandates, mandatory isolation of cases and their household contacts). The measures we use to respond to such waves in the future will be tailored to the situation.

32 Expanding access to antivirals and increasing their accessibility are key baseline measures that will help to lessen the impact of COVID-19 in future waves. New Zealand has improved its accessibility, with the reclassification of antivirals, pharmacist-only supply, and advance prescriptions. From mid-July 2022, anyone over 75 years of age who has tested positive for COVID-19 or anyone who has been admitted previously to an Intensive Care Unit directly as a result of COVID-19, has been eligible to access antivirals through their general practitioner. General practitioners can also now provide prescriptions to enable at-risk patients for acute respiratory illnesses to be preapproved and have their prescription ready should they become unwell and need the medicine immediately. Pharmac regularly reviews the access criteria for COVID-19 treatments and seeks input from its COVID-19 Treatments Advisory Committee to ensure the treatments are targeted to the populations with the highest needs and greatest potential to benefit based on the latest evidence. In addition, Manatū Hauora is working with Care in the Community to monitor the uptake of different antivirals, and outcomes.

Removal of measures

33 On 17 August 2022 a public health risk assessment was held to assess the COVID-19 public health measures that remain mandated:

33.1. air and maritime border requirements (including post-arrival testing, vaccination requirements for travellers and crew, provision of contact tracing information, requirement not to exhibit symptoms);

33.2. vaccination mandates (for health and disability workers);

33.3. isolation for cases and household contacts; and

33.4. masks.

34 Appendix 2 outlines the mandated measures in place now and in place from mid-September, based on the public health risk assessment and endorsement from the Director-General of Health.

Traveller and air crew vaccination

35 The Director-General of Health recommends removing all COVID-19 vaccination requirements for international arrivals, including air and relevant maritime crews. This requirement now has limited public health benefit in reducing the burden on the health system and is no longer considered proportionate in the current context.

36 Air crew and arrivals vaccination requirements were initially introduced in November 2021, in the context of the Delta variant. At that time, all arrivals entered managed isolation and quarantine (MIQ), and the vaccination mandate was an additional tool to reduce transmission and the risk of COVID-19 being introduced into the community.

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With Omicron, and the recognition that available vaccines are less effective in reducing transmission, the current rationale is more about reducing the risk of severe illness, and the potential impact on the health system.

37 As most arrivals are not subject to this requirement (though this could change as more tourists visit New Zealand), and as there is widespread COVID-19 in the community, the context is substantially different from when the vaccination requirement was introduced. Air carriers and maritime vessels (such as cruise ships) could still require evidence of vaccination if they so choose.

Post-arrival testing

38 Post-arrival testing mandates are also recommended to be removed and replaced with guidance to test on a voluntary basis. The recommendation of the Director-General of Health was that arrivals are encouraged to test with a RAT if symptomatic within a week of arrival, and if positive to get a polymerase chain reaction (PCR) test. I propose that post-arrival testing is still recommended in guidance for all air arrivals on day 0/1 and 5/6, and to get a PCR test if positive.

39 The rationale for post-arrival testing requirements is to provide extra surveillance for the early detection of new COVID-19 variants of concern. However, the current post-arrival testing requirement does not offer substantially greater benefit than other variant surveillance methods that are far less costly to the Crown and burdensome on individuals. If a highly transmissible variant was identified, it is likely that community transmission would have already occurred and been detected via other mechanisms (e.g., wastewater surveillance and PCR samples collected via community and hospital cases for whole genome sequencing (WGS)).

40 s9(2)(g)(i)

41 Instead of the mandatory post-arrival testing regime, through clear messaging and easy access to free RATs at the airport, arrivals can be encouraged, on a voluntary basis, to test on days 0/1 and 5/6 and advised where to obtain a free PCR test if they test positive through guidance. This would also include messaging on New Zealand's requirements to isolate if positive. Travellers would need to self-identify as a recent arrival when they go for a PCR test so the samples can be prioritised for WGS. As a voluntary regime, and without the mandatory feed of arrival contact data via the NZTD system, there would be no mechanism to provide reminders to arrivals to test or systematic monitoring or reporting of arrival RAT results.

42 s9(2)(f)(iv)

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Provision of information for contact tracing for air arrivals

44 While the electronic New Zealand Traveller Declaration (NZTD) has been a key enabler of the reopening of New Zealand's border, the NZTD will have a wider enduring function as a risk management platform beyond COVID-19 health requirements. It will allow more targeted risk assessment and management of travellers prior to arrival in New Zealand, facilitate better information sharing and planning between border agencies, and make compliance with entry requirements easier for travellers to New Zealand. These wider functions are expected to be in place by June 2023.

45 The Director-General of Health recommends that the requirement to provide contact details and travel history information via the NZTD system for air arrivals should be retained to enable timely contact tracing, should this be needed.

46 While travellers must also provide this information in the paper arrival card, this does not provide as timely or reliable a pathway as the NZTD. As a preparedness measure our ability to respond to a potential new variant of concern identified offshore relies on being able to effectively contact trace at pace. On balance the maintenance of this provision is warranted. s9(2)(f)(iv)

Travellers to New Zealand not to exhibit symptoms or be under a public health direction

49 Air travellers to New Zealand must not exhibit COVID-19 symptoms or be subject to a public health direction in another country. The Director-General of Health recommends that these requirements be removed. The purpose of the requirement is to prevent further seedings of infection into the community and to protect the New Zealand health system. However, given the current level of cases and hospitalisations in New Zealand, the reducing strain on the health system, and that people may be pre-

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symptomatic or asymptomatic, there is no strong rationale for maintaining this requirement in the COVID-19 Public Health Response (Air Border) Order 2021 (the Air Border Order). We will continue to ask that people not travel if they have COVID-19.

50 There are also administrative problems with this requirement as:

50.1. The specified symptoms of COVID-19 are the same as the symptoms for a wide range of conditions that we do not prevent people travelling for such as hay fever, allergies and the common cold. People attempting to board a flight with these symptoms may be unreasonably prevented from travel if the symptoms are caused by a condition other than COVID-19. While the Air Border Order provides an exception to this if the person has a supervised negative test result or a certificate from a medical professional, requiring this places a burden on travellers that Manatū Hauora no longer consider to be justified.

50.2. It cannot be enforced centrally through systems such as the NZTD. It is up to the airlines to determine whether someone is exhibiting COVID-19 symptoms and we do not have a way of monitoring how affective the requirement has been.

Vaccination mandates for health and disability sector workers

51 The Director-General of Health recommends removing the remaining COVID-19 vaccination mandates for health and disability sector workers.

52 This mandate was initially enacted to protect workers in high-risk settings and help prevent transmission between workers and vulnerable people. Population immunity is substantially more complex than when the vaccination mandate was introduced, when there was a clear demarcation in risk of infection between vaccinated and unvaccinated individuals. The range of different vaccination schedules, the time since vaccination, immunity due to infection, and the role of new variants are now important variables in the risk of COVID-19 infection. Our experience with Omicron is of limited COVID-19 transmission in health settings because of other mitigations (e.g., ventilation, personal protective equipment).

53 Workplaces may still consider an employer or person conducting a business or undertaking (PCBU) vaccination requirement is appropriate based on a work health and safety risk assessment under the Health and Safety at Work Act 2015. This is likely to be justified only where the risk assessment identifies that the risk of contracting and/or transmitting COVID-19 at work is higher than it is in the community. Employers also need to ensure that they follow usual employment law processes when dealing with any issues that arise under an employer or PCBU vaccination requirement. Given the public health advice above it is appropriate these decisions now be made by employer or PCBUs.

54 Since the review of the COVID-19 Public Health Response (Vaccinations) Order 2021 (the Vaccinations Order) began in July 2022, Manatū Hauora has been working with health sector and other agencies whose staff are affected by the mandate. Manatū Hauora will work with Te Whatu Ora and the Ministry of Business, Innovation and Employment to provide guidance to support agencies to prepare for the proposed change.

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55 The public health advice also noted that continued vaccination mandates may also increase legal risk given the limited effectiveness of COVID-19 vaccines at preventing transmission and COVID-19 infection being widespread in New Zealand. The Government would no longer operate centralised exemption schemes. Any provisions regarding exemptions from vaccination requirements would be created and maintained by individual PCBUs.

56 I therefore propose to remove these worker vaccination mandates.

Self-isolation of cases

57 The Director-General of Health recommends retaining mandatory seven-day self-isolation of COVID-19 cases. Isolation of infectious cases remains an important way to reduce transmission by preventing infectious people from having contact with others. Removing case isolation while there is still a high degree of COVID-19 circulating in the community risks prolonging or increasing the severity of an outbreak.

58 Current provisions on reinfection will continue to apply. A person is not considered a COVID-19 case and will not be required to self-isolate if they previously self-isolated as a case and there have been 28 days or fewer between day 0 of their self-isolation period and the day they again test positive.

Isolation of household contacts

59 The Director-General of Health recommends that the requirement for household contacts to isolate for seven days should be replaced with a recommendation to test daily for five days. A household contact would no longer be required to stay home while they continued to test negative. Any household contacts who test positive would be required to isolate as a case for seven days. Household contacts who are unable or unwilling to test are recommended to stay home for five days.

60 On the basis of proportionality, the current outbreak context, and overseas experience, daily testing of household contacts provides a sufficient risk mitigation if isolation is removed. The rationale of testing asymptomatic household contacts is to detect early any pre-symptomatic or asymptomatic infections so they can isolate early.

61 Disabled people, including tāngata whaikaha, remain more at risk of the broad impacts of COVID-19, such as workforce shortages, adverse infections, and isolation. Anecdotal evidence suggests that long COVID-19 disproportionately impacts disabled people by exacerbating existing impairments and introducing new ones. Typical examples are chronic fatigue syndrome, asthma, and other respiratory issues. s9(2)(g)(i)

62 Government messaging (in alternate formats, at the same time as general population messaging) will be critical to building confidence for disabled people, including tāngata

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whaikaha Māori and their whānau. It will help reinforce that disabled people are part of our recovery from COVID-19.

63 Whaikaha recommends that the accessibility of information, facilities, services and programmes in the COVID-19 recovery is reviewed (e.g., clear guidance and accessible pathways to access communications in plain language and alternative formats, guidance on how to remain safe and participate in the community, and access to Care in the Community resources). Whaikaha also recommends that a clear pathway for disabled people to access long COVID-19 support be actioned.

64 s9(2)(f)(iv)

65 I also suggest guidance for household contacts to wear a mask while outside of their house during the time their household case is isolating. Public health advice is that any recommendations to wear masks outside the home should be more targeted e.g., when visiting an ARC facility or certain indoor settings, rather than a blanket approach.

66 While removing household isolation would result in some increase in cases, on balance it was marginal when considering the large impact isolation itself was having on larger households especially, and wider society. CMA modelling suggests that this shift will result in a 2.5 percent increase in transmission, compared to 5 percent if contacts only test if symptomatic (see Appendix 1). Therefore, noting lead times and the outcome of consultation, public health advice is that now is the right time to remove the requirement.

67 Manatū Hauora considers that the wide availability of RATs will ensure there are minimal logistical issues; household contacts will continue to have access to free RATs. As at 17 August 2022, our RAT supplies are over 63 million in stock. Current RAT appropriations are spent, so any further RATs required would require additional funding. Te Whatu Ora planning for RAT supplies and funding is underway.

68 The Close Contacts Exemption Scheme and bubble-of-one will no longer be required as a consequence of removing isolation requirements for household contacts. MBIE will lead changes to these schemes.

Masks

69 The Director-General of Health recommends retaining mask requirements on public transport and in healthcare settings (including ARC) but removing mandates in other settings.

70 Health settings include, but are not necessarily limited to: primary care, urgent care, hospitals, ARC and disability-related residential care. Requirements apply to visitors only, not staff, healthcare workers, patients or consumers. Manatū Hauora provides infection prevention and control guidance to workers on recommended personal protective equipment (PPE) in different healthcare settings.

71 Public transport includes buses, commuter trains, and domestic flights. It does not include arrivals on international flights (as currently required in the Air Border Order). Public health guidance suggests that although requiring masks on inbound international flights would reduce the seeding of new variants, in practice, because

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many other countries do not have this requirement, and travellers to New Zealand will mix with these travellers if their journey encompasses more than one flight, the effectiveness of this measure would be reduced.

72 Retaining mask requirements in essential close contact (e.g., public transport) and healthcare settings is commensurate with the changing risk profile. Other essential services (e.g., supermarkets) have shown to be lower risk settings, largely due the amount of time people are in close contact and better ventilation. On public transport, there is evidence to suggest that carbon dioxide levels (which are a proxy for COVID-19 transmission risk) can reach high levels particularly if crowded and the trip is long.

73 However, mask settings are a key measure that would need to be ramped up if the COVID-19 risk increases. The Director-General of Health noted that recommending, rather than requiring, masks would have value in responding to mask fatigue. Retaining mask requirements now could increase mask fatigue and mean that if the COVID-19 risk increases and we need to increase mask use, people will be less likely to wear a mask when we most need them to. I therefore propose to remove mask requirements from public transport as well as from other settings where they are currently required (e.g., retail) but provide strong guidance on the wearing of mask in public transport.

74 The Director-General of Health also recommends that guidance be developed to encourage ongoing use in other settings. This guidance would supersede current masking recommendations – such as wearing masks anytime you are outside your home.

75 New guidance for when masks would be recommended, but not required, would cover both personal factors and specific settings. Personal factors would be factors would be specific to an individual's circumstances including:

75.1. household contacts or individuals that have had a known close contact exposure within the last seven days to reduce risk of infecting others;

75.2. individuals at higher risk of severe illness – to reduce the risk of them becoming infected; and

75.3. individuals that want to reduce their risk of becoming unwell, such as before an important event or holiday – to reduce their risk of becoming infected.

76 Specific settings would cover specific places that do not meet the threshold of mask requirements, including:

76.1. settings where there are many vulnerable people present in an indoor space;

76.2. public transport;

76.3. international flights; and

76.4. other crowded indoor spaces where you cannot physically distance.

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77 Manatū Hauora will develop comprehensive guidance on the personal factors and specific settings, prior to any public announcement. The final content may update the provisional content for personal factors and specific settings.

78 The approach of recommending but not requiring masks is already implemented in education settings. I propose that Manatū Hauora and the Ministry of Education report back to me and to the Minister of Education on whether the current mask guidance in schools should be amended before we publicly announce these changes.

79 Masks reduce transmission, but there is a difference between the value of masks as a tool and mask mandates. The key difference between a mask mandate and strongly recommending mask use is that evidence suggests adherence is higher when there is a mandate. However, as noted above, at this stage of the second Omicron wave, previous evidence on mandating may not be as relevant. From a public health perspective, Manatū Hauora notes that strongly recommending (rather that requiring) masks would have value in supporting a stronger focus on ensuring that the interventions to encourage and support mask use were in place, less stigmatising for disabled people and others unable to wear a mask, and responding to mask fatigue. However, if the COVID-19 risk was to increase, mandating masks in more settings may be appropriate.

80 Māori, Pacific peoples, disabled people, and people living in areas of high deprivation are likely to be disproportionately affected if mask mandates were removed and replaced with strong recommendations. It could also make at risk populations feel less comfortable and be at greater health risk taking part in everyday activities. Ongoing mask use is a highly useful "COVID-19 legacy" but will require time to become a behavioural norm. Removal of all mandates at this time could decrease the ongoing adoption of mask use.

81 s9(2)(g)(i)

82 As mask requirements are currently given effect to through the CPF settings, except for mask requirements for aircrew and travellers, I propose to make a new order to give effect to these revised mask requirements that can easily be amended to allow for an extension to settings if cases surge.

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Rights to access essential goods and services

83 Under the COVID-19 Protection Framework Order, the rights of people to access goods and services from certain designated premises is protected. The rationale for this protection was to ensure that people could access key services and such as supermarkets and pharmacies, irrespective of their vaccination status. This provision was particularly important when mandatory My Vaccine Pass (MVPs) requirements were in place prior to April 2022. However, I consider that there is no longer a rationale for retaining this provision. In keeping with the shift away from the CPF and using existing legal mechanisms to prevent discrimination and protect health and safety, I propose that this measure is not carried into a post CPF order.

84 s9(2)(f)(iv)

Impacts on COVID-19 support schemes

85 Self-isolation requirements are supported by two welfare programmes: the Leave Support Scheme and the Care in the Community welfare response. Between early February and early April 2022, the Leave Support Scheme paid out around $33 million per 100,000 cases. Since April, this has reduced to around $28 million per 100,000 cases. s9(2)(f)(iv)

86 s9(2)(f)(iv), s9(2)(j)

87 s9(2)(f)(iv)

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s9(2)(f)(iv)

89 The Arts and Culture Event Support Scheme (ACESS), administered by the Ministry for Culture and Heritage, is designed to help organisers of arts and cultural events have confidence to commit to and deliver events under the COVID-19 Protection Framework. The ACESS is open until 31 January 2023 and provides financial coverage for eligible, registered events that have to cancel because of restrictions imposed by a move to the Red setting of the COVID-19 Protection Framework, experience an overall financial loss during the first six-weeks after a transition from Red to Orange, or cancel because a lead performer has COVID-19 or is required to self-isolate. As of 23 August 2022, $28 million of payments to event organisers have been approved under this scheme. The removal of the CPF may require the Minister for Arts, Culture and Heritage to approve adjustments to the criteria that can trigger a payment under the ACESS. However, it will be significantly less likely for an event to be cancelled so the overall costs of the scheme are expected to decrease.

Work to improve health system capacity

90 COVID-19 and wider seasonal illness challenges have caused significant pressures on healthcare providers in terms of demand for services, due in part to staff pressures. In response, Te Whatu Ora has introduced a nationally consistent seasonal pressures operating model including new ways of working at regional and national level and a set of priority actions for adoption. Escalation processes of regional coordination and standardised triggers and thresholds have been introduced and refinement work based on early experiences is underway.

91 In community and primary care, early progress has been made in pilots to provide virtual clinical support e.g., districts expanding access to community radiology. There is also further work on expanding Primary Options for Acute Care.

92 Improving hospital flow is key to maximising capacity. There has been widespread rapid adoption of full capacity protocols. Good progress has been made on providing additional support from specialties to emergency departments to avoid preventable admissions and expedite admissions to the appropriate ward. Priority has been given to increasing capacity for weekend discharge.

93 Te Whatu Ora districts have made available extensive support to ARC providers to facilitate expediting discharge from hospital. Medical and nursing support is being made available to ARC facilities. Districts are implementing staff bureaus and other

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models to share staff capacity noting staffing support to ARC can limit staff available for other initiatives.

94 s9(2)(f)(iv)

Responding to variants of concern

95 In June 2022 I advised that, should a new variant of concern be identified, Manatū Hauora will assess its likely health impact in the New Zealand context and the Director-General of Health will alert COVID-19 Ministers if this assessment suggests severe adverse health outcomes are likely [CAB-22-MIN-0223].

96 If the public health advice suggests that severe adverse health outcomes are likely (e.g., if the worst-case variant of concern were to be identified, with high clinical severity and high immune evasion), proportionate reserve measures (e.g., increased mask use and mandatory isolation of household contacts) may be implemented to respond.

97 On 9 August 2022, DPMC held an all-of-government exercise to test system readiness to respond to a variant of concern with high clinical severity and high immune evasion (the worst case). The exercise confirmed that, similar to previous COVID-19 outbreaks, an outbreak of a variant of concern will require an all-of-government response. It also affirmed that there is a shared understanding across government agencies of what is required to respond to the worst-case scenario and tested the systems and processes to operationalise the response.

Regional impacts of our change in approach

98 While the current COVID-19 situation continues to vary across the region, Pacific countries are increasingly prepared to manage the ongoing effects of the pandemic and we continue to support Pacific partners to plan for and respond to COVID-19 through a range of assistance. As we transition our domestic approach, we anticipate partner governments will continue to look to New Zealand settings to inform their own approaches. Officials consider any increased risk resulting from flow on effects from our change in approach to be manageable, because of the trend towards easing restrictions across the region, Pacific governments' experience with managing domestic COVID-19 outbreaks, and our continued planning and preparedness support.

Future legislative basis

99 The Epidemic Preparedness (COVID-19) Notice 2022 (the epidemic notice) is due for renewal by 15 September 2022. The epidemic notice enables the creation of orders under the COVID-19 Act. The Director-General of Health has provided advice to the Prime Minister and other relevant Ministers on the renewal of the epidemic notice.

100 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 significantly disrupt essential governmental and business activity in New Zealand (or the parts of New

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Zealand concerned) significantly. It has been renewed by the Prime Minister every three months since the epidemic was first declared with the agreement of the Minister of Health and the Minister for COVID-19 Response and on recommendation of the Director-General of Health.

101 COVID-19 orders may only be made while the epidemic notice is in force, while a state of emergency or transition period in respect of COVID-19 under the Civil Defence Emergency Management Act 2002 is in force, or if the Prime Minister has authorised the use of COVID-19 orders, either generally or specifically.

102 [LEGALLY PRIVILEGED] s9(2)(h)

104 s9(2)(f)(iv)

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Process for decisions on measures

106 To give effect to the new approach, clear processes will be used to review the measures in place and scale measures up or down when required. I intend to refine the decision-making processes that have been used throughout our COVID-19 response, which have ensured our response has been centred on public health advice while incorporating an all-of-government perspective.

107 In June 2022, I described the process we will use for advising on outbreaks or future variants, where Manatū Hauora will convene a public health risk assessment (PHRA). These PHRA will draw on public health, scientific, and clinical information, identify potential response measures, and if required identify an appropriate mix of response measures to meet health objectives in proportionate and justifiable way.

108 As Minister for COVID-19 Response, I will keep settings under review based on public health advice monthly. Regular PHRA will continually review any reserve measures in place (as well as other baseline measures).

109 I will continue to follow the requirements of the COVID-19 Act, including the Bill of Rights Act, when making COVID-19 orders to give effect to reserve measures. When implementing a new reserve measure, I will consult with Ministers and/or come to Cabinet with recommendations as appropriate.

110 In June Cabinet noted that in addition to public health advice, advice on response measures will give consideration to the non-health factors previously agreed by Cabinet [CAB-22-MIN-0223; CAB-22-MIN-0114]. As I advised in June, these factors were suitable through the pre-Delta, Delta, and Omicron outbreaks and I have no reason to expect that this will change when applied to new variants. Impacts on international relationships, particularly with regard to the Pacific, will also be considered.

Consultation

111 This paper was prepared by the COVID-19 Group in the Department of the Prime Minister and Cabinet. The following agencies were also consulted on the paper: New Zealand Customs Service, 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, Manatū Hauora, Ministry of Housing and Urban Development, Ministry of Justice, Ministry for Pacific Peoples, Ministry for Primary Industries, Ministry for 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.

112 Manatū Hauora did not have time to consult with equity groups, particularly Māori, Pacific peoples, and disabled groups, during the development of the public health advice. DPMC has carried out engagement based on draft public health advice with the Strategic Public Health Advisory Group, representatives from nine disability groups, and members of the National Iwi Chairs Forum (NICF). Recent updates to advice on masks and household contact testing have not been discussed with external groups. Further engagement with NICF members occurred on 31 August and

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with other Māori leaders, not affiliated with the NICF, on 1 September. Feedback from these groups is reflected through the paper. Manatū Hauora also met with Te Rōpū Whakakaupapa Urutā on 1 September.

113 The Strategic Public Health Advisory Group discussed the relative benefits of mandatory measures and guidance. Their advice was it needs to be considered differently for different measures depending on whether or not New Zealand was in a crisis situation. Their general message was there is a need to transition away from broad mandates to more normal public health arrangements for COVID-19 and to keep the bar high for the use of broad mandatory measures, while retaining the ability for bespoke mandates to help protect people in high-risk occupations. They consider there is a lot of confusion about what current measures are, given frequent changes. They also considered that support for economically vulnerable people to stay home when sick should be an important baseline measure.

114 A range of views were provided from the RLGs. There were mixed views about removing the CPF; some RLGs suggested that because the CPF is familiar, and noted growing change fatigue, keeping the current system but moving to Green may be preferred. Others were supportive of moving away from the CPF as it is losing relevance with the public and removing it will allow for a more agile approach. While some RLGs took a conservative approach to mask and vaccination mandates, and recommended keeping them in some capacity (particularly some mask requirements), there was very strong support for removing isolation requirements for household contacts. This support was contingent on retaining testing for household contacts, in some feedback. A few RLGs supported removing all restrictions and moving more towards putting the onus on the individuals to follow recommended public health advice. In particular, some noted that we should begin to treat COVID-19 more in line with other seasonal illnesses.

Financial Implications

115 As I advised in June, the shift in approach does not require additional funding, as baseline measures and current reserve measures are already funded. Funding of baseline measures will be a significant ongoing expense for the Government which is why we will keep baseline settings under review to ensure measures are operating at the appropriate scale relative to the COVID-19 risk. The ongoing economic impact and fiscal cost will continue to be key considerations.

116 Now that the COVID-19 Response and Recovery Fund has closed, the COVID-19 response and recovery should be part of standard service delivery and any new funding should be sought through the standard Budget process and managed against Budget allowances.

117 Urgent public health costs that cannot be met within baseline funding or wait until the next Budget cycle could be met by the public health tagged operating contingency of $1.2 billion [CAB-22-MIN-0129].

118 s9(2)(f)(iv)

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Legislative Implications

119 The proposals in this paper require amendments to Orders made under the Act. Moving to the new approach and adjusting mandated public health measures requires:

- 119.1. Revoking the COVID-19 Protection Framework Order;
- 119.2. Amending the Air Border Order;
- 119.3. Revoking the Maritime Border Order;
- 119.4. Revoking the Vaccinations Order;
- 119.5. Amending the COVID-19 Public Health Response (Self-isolation Requirements and Permitted Work) Order 2022 (the Self-Isolation Order); and
- 119.6. Making a new mask order.

120 Additionally, I intend to revoke the COVID-19 Public Health Response (Isolation and Quarantine) Order 2020, which sets out the requirements for people in managed isolation and quarantine, and the COVID-19 Public Health Response (Testing for COVID-19) Order 2022 (Testing for COVID-19 Order), which provides for the frequency and form of post-arrival testing to be established by Director-General notice.

121 I am also considering potential amendments to the COVID-19 Public Health Response (Point-of-care Tests) Order 2021 so that it can continue to support self-isolation of cases.

Impact Analysis

122 Manatū Hauora's Papers and Regulatory Committee has reviewed the attached Impact Assessment and considers it partially meets the quality assessment criteria. The analysis is reasonably convincing. It focuses on proportionality, and largely relies on the Public Health Risk Assessment (an internal workshop with a wide range of public health, policy and legal expertise), which is reasonable given the time constraints. The proposals have not been widely consulted upon, though this is mitigated to some extent by engagement with, in particular, the Iwi Chairs Forum, and future engagement planned. Effects on equity are unclear and should be very closely monitored. Given the nature of the changes, the Impact Assessment that was reviewed by the Papers and Regulatory Committee has not been updated following consideration by the Social Wellbeing Committee.

Human Rights [Crown Law Advice – Legally Privileged]

123 s9(2)(h)

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124 s9(2)(h)

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Population Implications

131 In June I advised of the population implications of the new approach: The burden of COVID-19 does not fall equally, and some people are at higher risk of adverse health outcomes from the virus. That is why I proposed that our baseline measures include targeted protections for the most vulnerable. For example, in the winter package we expanded access to antivirals, particularly for people at significant risk of poor outcomes from COVID-19, increased access to RATs, and increased the availability of medical masks, including to Pacific churches, marae, kaumatua facilities, ARC, and Māori and Pacific vaccination providers.

132 I am proposing to remove several mandated public health measures at the border and reduce measures domestically because the risks of COVID-19 are decreasing – making it safer to remove measures. Māori and Pacific Peoples contributed a greater proportion of fatalities earlier in the Omicron wave than more recently - Māori accounted for 13 percent of fatalities in April 2022, but only 7 percent in July, while Pacific Peoples accounted for 8 percent of fatalities in April, but only 3 percent in July. As the COVID-19 risks decrease, the negative cultural, social and economic impacts of restrictive measures are less justified. However, at whatever level or settings measures are at, COVID-19 could disproportionately affect populations groups such as older people, disabled people, Māori, Pacific peoples, and some ethnic communities.

Older people

133 Our experience of winter and Omicron is that older people are more likely to be hospitalised. The virus takes longer to move through this population due to this group having fewer social interactions, so there may be a higher hospitalisation burden over a longer period beyond winter.

Disabled people and tāngata whaikaha Māori

134 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 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 disabled people and some ethnic communities and their whānau. 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

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the future are likely to cause greater anxiety and risk for disabled people, particularly those with underlying co-morbidities.

135 The winter package expanded access to antivirals, but disabled people and tāngata whaikaha Māori are concerned about limited access criteria to antivirals, due to the current eligibility. Some disabled children and tamariki whaikaha Māori who cannot wear face masks may be at higher risk in environments where air ventilation can be variable, for example in some schooling and social indoor environments. s9(2)(f)(iv)

136 Replacing isolation of household contacts with guidance or requirements to test daily for five days may present an equity risk for disabled people and tāngata whaikaha Māori, who have experienced some barriers accessing testing resources. It will be important that disabled people, including tāngata whaikaha Māori, and whānau have access to testing options that suit their needs; work continues to explore alternative testing modalities outside of RATs and PCR tests. Extra support and strong communication are needed to ensure disabled people can meet this new requirement. Daily testing of household contacts may also not provide assurance to disabled people that they will be safe from the impacts of COVID-19, as it will rely on individuals to test.

137 Disability sector representatives noted that the sector is still feeling the impacts of the latest wave, with service providers under pressure and community members choosing to self-isolate to keep themselves safe. The removal of vaccination mandates, and reduced self-isolation requirements for household contacts will likely positively impact workforce capacity and therefore continuity of services. However, engagement with the disability sector raised the importance of ensuring disabled people and tāngata whaikaha Māori have choice and control over the vaccination status of their support workers.

138 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. While acknowledging that there are mask campaigns currently underway to encourage mask-wearing and improve understanding of why some people can't wear masks, some disability sector representatives were very concerned at the lack of general understanding on what it means to be vulnerable in New Zealand.

139 Without data disaggregated by disability, determining impacts of variants of concern or effectiveness of public health measures on disabled people and tāngata whaikaha Māori would be difficult. Without data, disabled people, including tāngata whaikaha Māori continue to be at-risk of exclusion from data driven policy considerations and it will be difficult to determine whether measures are working effectively for disabled people and tāngata whaikaha Māori.

Māori

140 The COVID-19 outbreak has worsened the already inequitable health outcomes for Māori. As measures are stepped down, Manatū Hauora's Māori Protection Plan is critical; this plan is currently due to expire in December 2022. Related response

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measures are expected to continue to have a positive impact for Māori, including the ongoing mandatory measures.

141 As noted above, we have some well-established baseline measures in place, including high vaccination rates. Across all ethnicities, 91.5 percent of people are at least partially vaccinated, and 73.1 percent of people eligible for first boosters have received them. For Māori, 86.6 percent of people are at least partially vaccinated and 56.1 percent of Māori eligible for first boosters have received them. While we have high vaccination rates for at least one dose, there is more work to be done in encouraging booster vaccination uptake among Māori.

Pacific peoples

142 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 four time greater than European or other ethnicities.

143 91.4 percent of Pacific peoples are at least partially vaccinated (compared to 91.5 percent across all ethnicities) and 60.8 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.

144 To respond to the impacts of Omicron, the Ministry for Pacific Peoples is currently delivering the Pacific Aotearoa Community Outreach fund which supports Pacific communities to prepare, respond and build resilience to COVID-19. The funding provided Pacific organisations, churches, and community providers to deliver testing and vaccination centres to increase update in Pacific communities, provide isolation support packages, undertake targeted outreach engagements to disseminate COVID-19 messages and enable digital accessibility and connectivity especially for hard-to-reach communities.

Other groups

145 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.

146 Removing the requirement for household contacts to self-isolate will 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.

147 Transitioning from mandatory isolation of household contacts 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.

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Te Tiriti o Waitangi analysis

148 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.

149 Engagement to date has highlighted 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 service providers are therefore experiencing high workforce fatigue.

150 The CPF has necessarily relied on public goodwill for compliance, and we have recently seen compliance with measures such as masks, waning. The new approach 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). 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.

151 Officials engaged with NICF members about New Zealand's approach to variants of concern and the new approach in May and about stepping down mandatory measures in August. In discussions 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. This would support the removal of broad-based population requirements such as the CPF. 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. Officials will provide support as needed to develop any guidance. NICF members wished ministers to be aware that they are looking for a guarantee that any measures removed will be reintroduced when necessary. NICF members have also observed the hardship that requiring household contacts to isolate placed on many whānau, particularly larger households where infections came in waves and people may be precariously employed.

152 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. In discussion with Māori leaders not affiliated with the NICF, they noted the inter-connected nature of the social, economic, and health inequities facing our most vulnerable communities, including iwi Māori. The COVID-19 pandemic has exposed and exacerbated these inequities.

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Communications

153 I propose the launch of the new approach and adjustments to mandated public health measures are announced on 12 September 2022. This time allows for implementation (e.g., guidance for household contact testing), drafting of orders, and finalising communications material.

154 Following Cabinet decisions, I will work with relevant Ministers ahead of announcements to ensure that specific sectors have an early indication of the changes to come. This includes the aviation sector, to have time to implement border changes, the disability sector, Māori and Iwi, Pacific Peoples, and relevant governments, including in the Pacific, to notify them of Cabinet decisions ahead of the announcement.

155 Domestic and border measures can be implemented from 11.59pm on the day of announcement, provided announcement is not brought forward. Changes to domestic vaccination mandates will come into effect on 11.59pm on 26 September 2022 to allow PCBUs time to consider ongoing vaccination requirements.

156 It will be important to provide assurance to the population that our move to the new approach will provide greater stability. I therefore consider there would be no value in proactively signalling future changes on the day of announcement.

Proactive Release

157 This paper will be proactively released following Cabinet consideration.

Recommendations

The Minister for COVID-19 Response recommends that Cabinet:

1. note that in July 2022, Cabinet agreed to a new COVID-19 strategy for post-winter 2022 and invited the Minister for COVID 19 Response to report back in August to advise on whether it is appropriate to revoke the COVID-19 Public Health Response (Protection Framework) Order 2021 (the COVID-19 Protection Framework Order) and move to the new strategy [SWC-22-MIN-0118];

2. note that as part of the above decisions, Cabinet agreed to the new approach of prepared, protective, resilient and stable to replace the minimise and protect strategy currently in place, which will be given effect to through an approach of relying on baseline measures with more restrictive reserve measures kept for use in emergency circumstances;

3. note that it is timely to remove the COVID-19 Protection Framework and move to the new approach, as we have well-established baseline measures, high vaccination rates and low case numbers, and consequently declining health system demand from COVID-19;

Transition to the new long-term approach to managing COVID-19

4. agree to revoke the COVID-19 Protection Framework Order and thereby remove the COVID-19 Protection Framework;

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Removal of measures

5. note that on 17 August 2022 a public health risk assessment was held to assess the following COVID-19 measures that remain mandated:

    5.1. air and maritime border requirements (including post-arrival testing, vaccination requirements for travellers and crew, provision of information);

    5.2. vaccination mandates for health and disability workers;

    5.3. isolation for cases and household contacts; and

    5.4. mask requirements;

6. note that the Director-General of Health recommended:

    6.1. removing COVID-19 vaccination requirements, post-arrival COVID-19 testing requirements (replaced with recommendations to test), and requirements not to exhibit COVID-19 symptoms or be under a public health direction for arrivals;

    6.2. retaining requirements for air travellers to provide information for contact tracing purpose prior to departure;

    6.3. removing all remaining COVID-19 vaccination mandates;

    6.4. retaining mandatory self-isolation of cases;

    6.5. retaining masks requirements on public transport, including buses, commuter trains, domestic and international flights (arrivals), and for visitors in healthcare settings including hospitals, primary care, counselling, mental health and addiction, and aged residential care (health care workers are covered by infection prevention and control guidance);

    6.6. replacing self-isolation requirements for household contacts with guidance to test daily for five days;

7. agree to:

    7.1. remove COVID-19 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;

    7.2. remove all remaining COVID-19 vaccination mandates; and

    7.3. remove mandatory self-isolation of household contacts, to be replaced with guidance only to test daily for 5 days;

8. note that the Director-General of Health has provided advice to the Prime Minister and other relevant Ministers for consideration in parallel with this paper and prior to 15 September 2022, when the epidemic notice is due for renewal, on the legislative basis for ongoing COVID-19 restrictions;

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9. agree in principle, subject to confirmation of the legislative basis in paragraph 8, to:

   9.1. retain mandatory self-isolation of cases;

   9.2. retain requirements for air travellers to provide information for contact tracing purpose prior to departure; and

   9.3. retain masks for visitors in healthcare settings only including primary care, urgent care, hospitals, aged residential care and disability-related residential care but excluding counselling, mental health and addiction services;

10. agree to provide strong guidance on the wearing of masks on public transport;

11. note that on 5 September, Cabinet agreed in principle to paragraph 7, 9 and 10, subject to confirmation on 12 September 2022;

12. s9(2)(f)(iv)

13. note that the Minister for COVID-19 Response intends to implement these changes in recommendations 7, 9, and 10 by:

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

    13.2. revoking the COVID-19 Public Health Response (Maritime Border) Order (No 2) 2020;

    13.3. revoking the COVID-19 Public Health Response (Vaccinations) Order 2021;

    13.4. amending the COVID-19 Public Health Response (Self-isolation Requirements and Permitted Work) Order 2022; and

    13.5. making a new mask order that retains mask requirements in healthcare settings (including aged residential care) only;

14. note the mask order, like any order, can be amended quickly if needed to respond to an increase in COVID-19 risk, based on public health advice;

15. s9(2)(f)(iv)

16. agree that the launch of the new approach and adjustments to mandated public health measures are announced in the week of 12 September 2022;

17. note that changes to domestic and border measures will be in place from 11.59pm on the day of announcement, except for changes to domestic vaccination mandates which will come into effect on 11.59pm on 26 September 2022;

18. s9(2)(f)(iv)

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Impacts on COVID-19 support schemes

19. note that household contacts will no longer be eligible for the Leave Support Scheme if they are not legally required to self-isolate;

20. s9(2)(f)(iv)

21. note that modifying isolation requirements for household contacts will reduce demand for Care in Community welfare response supports;

22. note that Care in Community welfare programme is linked to self-isolation requirements to ensure that the programme is available to support low-income households to isolate safely and recover from impacts of COVID-19;

23. s9(2)(f)(iv)

Future legislative basis

25. note that the Epidemic Preparedness (COVID-19) Notice 2020 (the epidemic notice) is due for review by 15 September 2022 at the latest;

26. [LEGALLY PRIVILEGED] s9(2)(h)

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Processes for decisions on measures

29. note that, to give effect to the new approach, clear processes will be used to review the measures in place and scale measures up or down when required, building on the processes that served New Zealand well in reviewing COVID-19 Protection Framework settings, with a focus on the health system;

30. note that in addition to public health advice, advice on response measures will give consideration to the non-health factors previously agreed by Cabinet [CAB-22-MIN-0223; CAB-22-MIN-0114].

Authorised for lodgement

Hon Dr Ayesha Verrall
Minister for COVID-19 Response

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Appendix 1: Modelling on impact of public health measures in medium-term

1 COVID-19 Modelling Aotearoa (CMA) have undertaken parameter scenario modelling around baseline public health measures that could be in place over the medium-term. The scenarios modelled do not exactly reflect the proposed changes to measures, but do approximate them.

2 The approximate effects of the measures in the scenarios are:

a) Moving from status quo measures to reduced mask use (as proposed) and guidance to test for five days for household contacts (Option 1) increases transmission 8-9%. The approximation isn't exact (as the model assumes mask guidance only) so the actual increase is likely less.

b) Moving from status quo measures to reduced mask use (as proposed) and mandatory testing on days 3 and 5 for household contacts (Option 2) increases transmission 10-12%. The approximation isn't exact (as the model assumes mask guidance only and household contact testing if symptomatic) so the actual increase is likely less.

c) Moving to guidance only for masks and isolation (with assumed 50% of cases choosing to isolate and testing if symptomatic for contacts) increases transmission by 17-20%.

3 The impact of the above scenarios depends heavily on the environment and settings at the time of implementation, but using the mid-point of the estimated change in transmission (table below[1]) suggests that there is significant variation in the short term between scenarios in terms of cumulative infections, cases and hospitalisations, although peak hospital bed occupancy in all scenarios falls well short of past peaks.

	Peak hospital bed occupancy	**Cumulative infections**	**Cumulative cases**	**Cumulative hospital admissions**
Status quo	175	77.9K	31.8K	297
(a) Option 1 approximation	176	119.9K	47.5K	440
(b) Option 2 approximation	181	136.3K	53.5K	495
(c) Guidance only	226	200.3K	76.5K	707

Source: CMA Ordinary Equation Differential Model.

4 The public health advice recommends retaining seven days case isolation instead of a test to release policy at this time because test to release may keep people in isolation who are not infectious. While a positive RAT is correlated with infectiousness, this is not as strong a correlation as within the first week. Test to release is also more complicated to communicate.

[1] Cumulative metrics are for a 30-day period that starts 15 days after the policy change.

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5 Adding a one negative test (or two) test-to-release policy to the status quo (with a maximum isolation period of 10 days), is expected to lead to a reduction in the number of cases still infectious after release of 40 percent (or 60 percent), while the average isolation period will increase by 0.3 (or 0.6) days. The current evidence would support the assumption that after the first week of infection, a negative RAT is strongly correlated with non-culturable virus and that the individual is unlikely to be infectious. A positive RAT is correlated with infectiousness, but not as strongly as within the first week. At more than 10 days either a positive RAT or culturable virus are uncommon.

6 A scenario with a minimum isolation period of only 5 days, but using a two test-to-release policy with a maximum isolation period of 10 days, results in an expected decrease in risk, relative to the current policy, as well as a decrease in the overall time spent in isolation for confirmed cases. The current evidence would support the assumption that within the first week of infection, a positive RAT is strongly correlated with culturable virus and that the individual is infectious. However, a negative RAT early in the course of disease (before day 5) does not guarantee an individual will not be infectious. This option is complex to communicate.

7 This modelling is being refined and has not yet been subject to a formal peer review.

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Appendix 2: Mandated measures in place now and proposed to be in place from mid-September

	Current mandated measures	Mandated measures proposed from mid-September	Legislative impacts
Border post-arrival testing	All travellers entering New Zealand by air must test on days 0/1 and 5/6 and report their results. Those who test positive must get a follow-up PCR to enable WGS All cargo and fishing vessel crew must undergo post-arrival testing if coming ashore	No post-arrival testing requirements (replaced with guidance to test daily on days 0/1 and 5/6, targeted surveillance and information provision measures for travellers)	Amendments to the Air Border Order, revoking the Testing for COVID-19 Order and Maritime Border Order to remove post-arrival testing requirements
Border vaccination requirements for travellers	Travellers and aircrew are required to have completed a primary COVID-19 vaccination course unless under 17 years, are not New Zealand citizens or residents, or are Australians ordinarily resident, or otherwise exempt. Maritime arrivals via cruise ships and recreational vessels must also be vaccinated.	No vaccination requirements at the border	Amendments to the Air Border Order and revoking the Maritime Border Order to remove vaccination requirements
Border contact tracing	All air arrivals, prior to departure, must provide contact details while in New Zealand, and a travel history of countries visited in the past 14 days	No change	N/A
Worker vaccination	Certain health and disability sector workers to be vaccinated and boosted to work PCBUs have duties to uphold these requirements	No worker vaccination requirements (or subsequent duties on PCBUs)	The Vaccinations Order is revoked
Isolation of cases	Cases are required to isolate for 7 days from their positive test or from the onset of symptoms	No change	N/A
Isolation of contacts[2]	Household contacts are required to isolation for 7 days and test on days 3 and 7	No requirements for household contacts to isolate - replaced with guidance to test daily for 5 days	Amendments to the Self-Isolation Order
Masks	Comprehensive mask requirements exist under the Orange CPF setting including: on aircraft and public transport; parts of indoor premises that are open to the public; premises of a health service, if the person is not a patient or worker of the health service	Mask requirements retained in healthcare settings (including aged residential care) but removing mandates in other settings. Health settings include, but are not necessarily limited to: primary care, urgent care, hospitals, aged residential care and disability-related residential care. These requirements apply to visitors only, not staff, healthcare workers, patients or consumers nor to visitors in counselling and mental health and addiction services.	The CPF Order is revoked and replaced with a mask Order Amendments to the Air Border Order
Access to essential	The rights of people to access key services, irrespective of their vaccination status, is protected under the CPF Order.	Protections removed.	The CPF Order is revoked

[2] Household contacts that have had COVID-19 in the past 3 months or have completed quarantine as a household contact in the last 10 days do not need to quarantine.

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Regulatory Impact Statement: Review of Public Health Measures to support the future of the COVID-19 Protection Framework and moving to the new strategy

Coversheet

Purpose of Document	
Decision sought:	*Analysis produced for the purpose of informing: final Cabinet decisions on the removal of the COVID-19 Public Health Response (Protection Framework) Order 2021*
Advising agencies:	*Manatū Hauora-The Ministry of Health and Department of Prime Minister and Cabinet*
Proposing Ministers:	*The Minister for COVID-19 Response*
Date finalised:	*29 August 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 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 COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand
2. the post-arrival testing requirement for arrivals to New Zealand
3. the requirement for air travellers to New Zealand to provide information for contact tracing purposes prior to departure
4. the requirement for travellers to New Zealand not to exhibit symptoms or be under a public health direction
5. the requirement for household contacts to quarantine for 7 days
6. the 7-day case isolation requirement
7. the COVID-19 Public Health Response (Vaccinations) Order 2021 which includes the vaccination mandates for health and disability sector workers
8. the current masking settings, that require mask use when travelling on a range of transport options, in public venues, health care settings and retail settings among other places.

Executive Summary

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

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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. This is timely as these changes will inform the ongoing strategic approach for the public health response to COVID-19 as we look to move away from the COVID-19 Protection Framework.

To ensure the proposals are effective, justifiable and proportionate under the Bill of Rights Act, 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, we support the recommendations of the Public Health Risk Assessment to:

a. 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

b. remove the COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand (including for air crew)

c. retain the requirement for air travellers to New Zealand to provide information for contact tracing purposes prior to departure

d. 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

e. maintain the current 7-day case isolation requirement

f. revoke the COVID-19 Public Health Response (Vaccinations) Order 2021 and remove the remaining vaccination mandates for health and disability sector workers

g. retaining masks requirements on public transport and healthcare settings (including aged residential care)

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. Given condensed timeframes, further work is required to develop an appropriate evaluation framework and methodology.

Limitations and Constraints on Analysis

This proposal is subject to a number of limitations:

- Limited time to prepare this Regulatory Impact Statement
- Limited data available on the impact of the proposals given the fluid nature of the COVID-19 response

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- 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 DPMC.

Responsible Manager(s) (completed by relevant manager)

Stephen Glover

Group Manager, COVID-19 Policy

Strategy, Policy and Legislation

Manatū Hauora

29/08/2022

Alice Hume

Head of Strategy & Policy

COVID-19 Group

Department of Prime Minister and Cabinet

29/08/2022

Quality Assurance (completed by QA panel)	
Reviewing Agency:	Ministry of Health
Panel Assessment & Comment:	The Ministry of Health's Papers and Regulatory Committee has reviewed the attached Impact Assessment and considers it partially meets the quality assessment criteria. The analysis is reasonably convincing. It focuses on proportionality, and largely relies on the Public Health Risk Assessment (an internal workshop with a wide range of public health, policy and legal expertise), which is reasonable given the time constraints. The proposals have not been widely consulted upon, though this is mitigated to some extent by engagement with, in particular, the Iwi Chairs Forum, and future engagement planned. Effects on equity are unclear and should be very closely monitored.

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Section 1: Diagnosing the policy problem

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

New Zealand's Elimination Strategy, and then the COVID-19 Protection Framework's (CPF) minimisation and protection approach since December 2021, have been successful in limiting the worst impacts of COVID-19. This has been achieved by adapting our response to the specific features of each COVID-19 outbreak and the availability of public health responses at the time (e.g. effective vaccination).

By all measures New Zealand's current COVID-19 outbreak is waning, with reducing case numbers, hospitalisations, and deaths. Modelling suggests this trend should continue for some time. However, it is still unclear when the outbreak will plateau.

The most likely medium-term COVID-19 outlook for New Zealand suggests waves of COVID-19 infection and reinfection, as seen internationally. However, the actual trajectory and severity of future outbreaks remains uncertain due to the likelihood of new variants of concern. 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.

In July 2022, reflecting the changing outbreak context and limitation of the CPF, Cabinet agreed to shift to a new strategy for managing COVID-19 after winter 2022 [CAB-22-MIN-0251]. Going forward, we will be using a strategic approach with 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.

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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 COVID-19 context is 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 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 COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand
2. the post-arrival testing requirement for arrivals to New Zealand
3. the requirement for air travellers to New Zealand to provide information for contact tracing purposes prior to departure
4. the requirement for travellers to New Zealand not to exhibit symptoms or be under a public health direction
5. the requirement for household contacts to quarantine for 7 days
6. the 7-day case isolation requirement
7. the COVID-19 Public Health Response (Vaccinations) Order 2021 which includes the vaccination mandates for health and disability sector workers
8. the current masking settings, that require mask use when travelling on a range of transport options, in public venues, health care settings and retail settings among other places.

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.

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, and members of the National Iwi Chairs Forum (NICF). Recent updates to advice on masks and household contact testing have not been discussed with external groups. Further engagement with NICF members is planned for 31 August and Te Rōpū Whakakaupao Urutā the same week, date TBC, and with Iwi not affiliated to the NICF and Māori Organisations on Thursday 1st of September.

The Strategic Public Health Advisory Group discussed the relative benefits of mandatory measures and guidance. Their experience was different for different measures depending on

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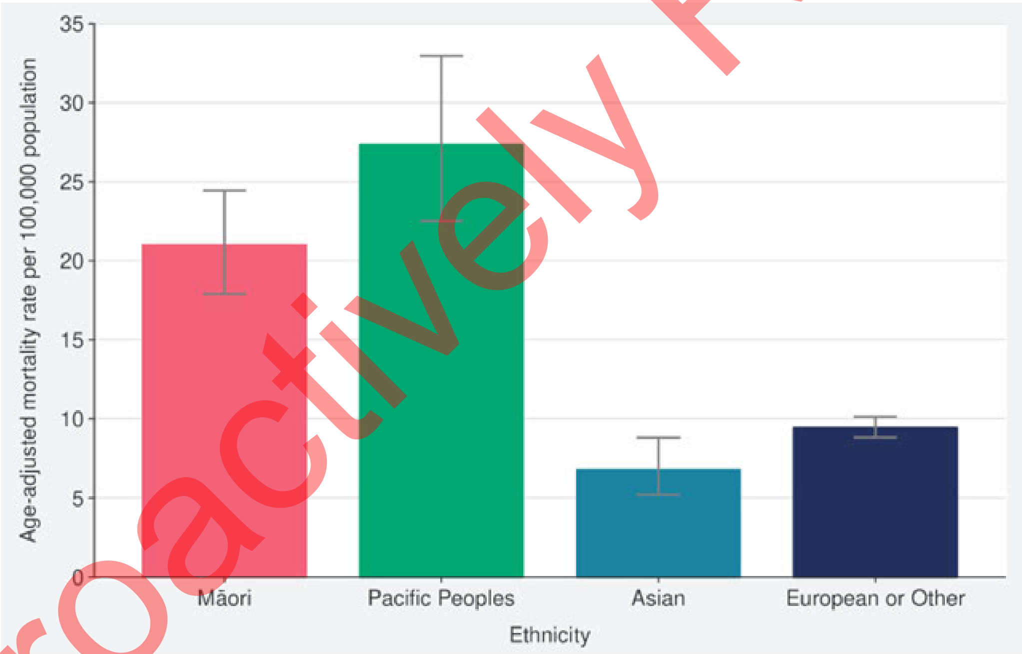
whether New Zealand in a crisis or not. Their general message was there is a need to transition away from broad mandates to more normal public health arrangements for COVID-19 and to keep the bar high for the use of broad mandatory measures. They consider there is a lot of confusion about what current measures are, given frequent changes. They also considered that support for economically vulnerable people to stay home when sick should be an important baseline measure.

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.

The burden of COVID-19 does not fall equally, and some people are at higher risk of adverse health outcomes from the virus.

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. Pacific Peoples had the highest cumulative incidence rate of hospitalisation with COVID-19, which was 1.4 times higher than Māori ethnicity, 3.4 times higher than European or Other ethnicity and 3.6 times higher than Asian Peoples (see Figure 3 below).

Figure 3 - Age-standardised cumulative incidence (and 95% confidence intervals) of hospitalisation with COVID-19 by ethnicity, March 2020 to 14 August 2022



Similarly, for total COVID-19 attributed mortality rates by ethnicity, Pacific Peoples had the highest rate which was 1.4 times higher than Māori ethnicity, 3.1 times higher than European or Other ethnicity and 4.2 times higher than Asian ethnicity.

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.

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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 the COVID-19 Protection Framework, 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 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:

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- 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.
- Ongoing review of the COVID-19 Protection Framework has identified that while it was effective in responding to Delta and Omicron initially, going forward we'll need a strategic approach that is more flexible and be better suited to the current context (as outlined in the context section).
- The Epidemic Preparedness (COVID-19) Notice 2022 (the epidemic notice) is due for renewal by 15 September 2022. The epidemic notice enables the creation of orders under the COVID-19 Public Health Response Act 2020 (the COVID-19 Act).

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

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.

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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:	
++	much better than doing nothing/the status quo/counterfactual
+	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
- -	much worse than doing nothing/the status quo/counterfactual

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The requirement for air travellers to New Zealand to provide information for contact tracing purposes prior to departure

Options

Option 1: Status-quo	Option 2: Remove the requirement for air travellers to provide information for contact tracing purposes
Retain the current requirement for arrivals to New Zealand to provide contact details and travel history information to assist contact tracing under the COVID-19 Public Health Response (Air Border) Order 2021.	Remove the requirement for arrivals to provide contact details and travel history

Public Health Risk Assessment recommendation

PHRA recommendation	That the requirement to provide contact details and travel history information as a condition of being able to depart for New Zealand is retained.

Multi-criteria assessment

Criteria	Option 1: (Status quo) the requirement for air travellers to New Zealand to provide information for contact tracing purposes prior to departure is retained	Option 2: The requirement to provide contact details and travel history information as a condition of being able to depart for New Zealand is removed, with other information gathering methods put in place that are not mandated under COVID-19 specific legislation.
s9(2)(h)		

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Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	The costs associated with gathering the information are likely to be the only costs associated with this measure.	+ Reduced government expenditure on this measure.
Equity- Evidence of the impacts of the measures for at risk populations	This has the potential to support a more effective response to new variants of concern, and with that provide greater protection to at risk communities.	- Without this measure, potential delays and limitations in providing timely contact tracing could slow down a response to a potential variant of concern.
Compliance- expected public compliance with measures	N/A Under this proposal, compliance is not an applicable criteria as it is has been a requirement of entry and option 2 is a removal of the requirement.	
Overall	On balance, and taking a precautionary approach, retaining this measure given the limited imposition that comes with it has the potential to support a more effective response to future variants of concern.	In the event of a future variant of concern, the potential implications for contact tracing prevent this from being the preferred approach.

2.The post-arrival testing requirement for arrivals to New Zealand

Options

Option 1	**Option 2**
Maintain COVID-19 post-arrival testing requirement for all air and maritime arrivals to New Zealand (including for air crew), noting the public health rationale is now lesser than before. Currently arrivals are required to take a Rapid Antigen Test on day 0/1 and day 5/6, to identify new cases and support surveillance for new variants of concern. When arrivals have a positive Rapid	Amend the COVID-19 Public Health Response (Air Border) Order 2021 and COVID-19 Public Health Response (Maritime Border) Order 2021 to remove the post-arrival testing requirement and replace it with targeted surveillance and information to support effective non-mandatory post-arrival testing

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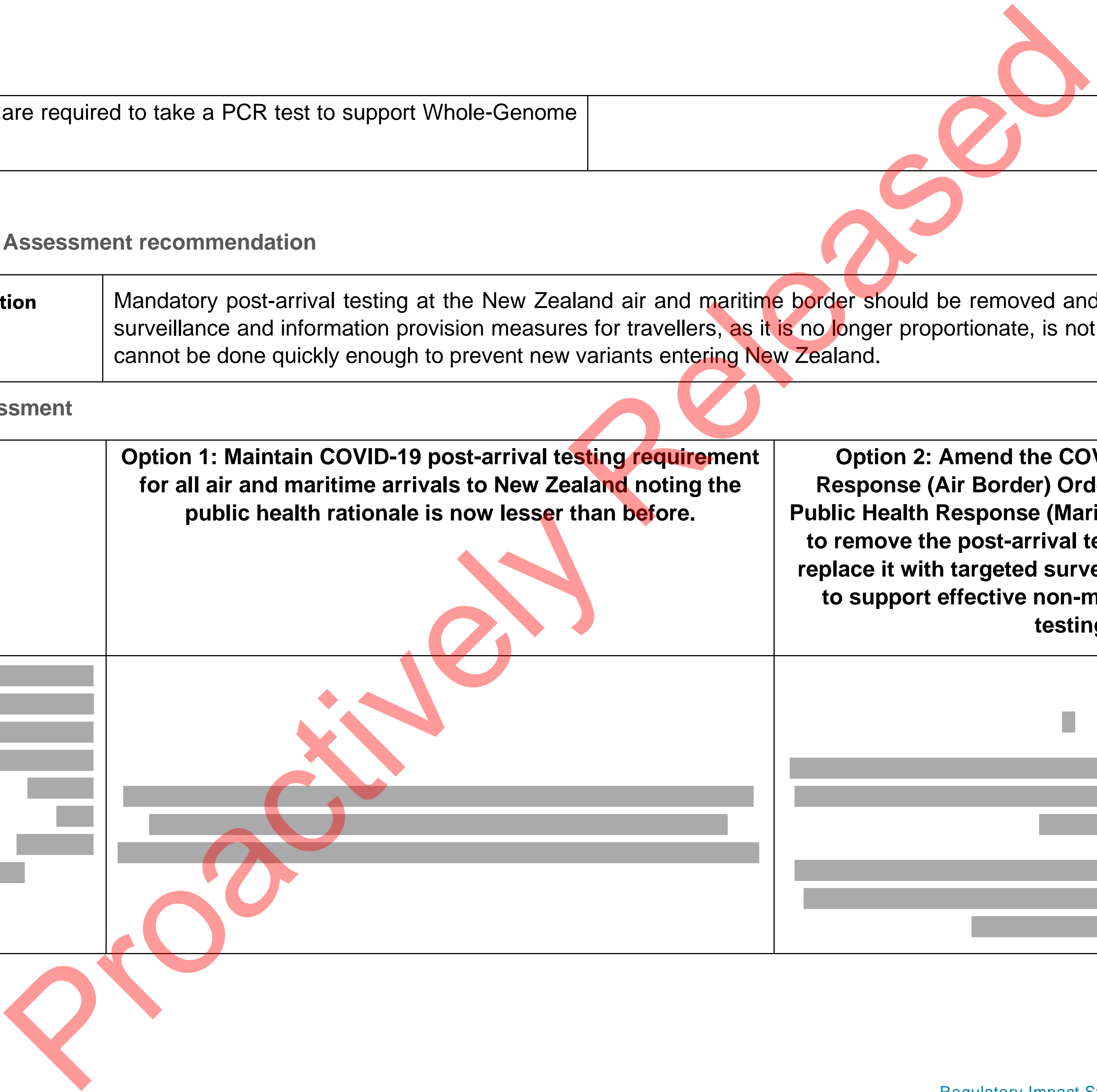

Antigen Test, they are required to take a PCR test to support Whole-Genome Sequencing.	

Public Health Risk Assessment recommendation

PHRA recommendation	Mandatory post-arrival testing at the New Zealand air and maritime border should be removed and replaced with targeted surveillance and information provision measures for travellers, as it is no longer proportionate, is not currently enforced, and cannot be done quickly enough to prevent new variants entering New Zealand.

Multi-criteria Assessment

	Option 1: Maintain COVID-19 post-arrival testing requirement for all air and maritime arrivals to New Zealand noting the public health rationale is now lesser than before.	**Option 2: Amend the COVID-19 Public Health Response (Air Border) Order 2021 and COVID-19 Public Health Response (Maritime Border) Order 2021 to remove the post-arrival testing requirement and replace it with targeted surveillance and information to support effective non-mandatory post-arrival testing**
s9(2)(h)		

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		Delays in WGS for border arrivals (in a context of increasing traveller numbers) mean that new Variants of Concern are likely to be identified in the community first.
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	Post-arrival testing is costly and does not have a significant benefit compared to other surveillance measures in place.	+ Reduces expenditure on a public health measure with limited benefit.
Equity- Evidence of the impacts of the measures for at risk populations	Limited effectiveness, although substantially not more effective than maintaining other surveillance methods in protecting at risk populations.	Ongoing effective surveillance methods would still be in place, and targeted recommended testing for symptomatic cases would remain in place.
Compliance- expected public compliance with measures	Compliance has remained high, however this may wane as other countries move away from this approach and the perception of the public health benefit changes.	+ Compliance for the less intensive regime would be supported by proactive support and clear messaging. Furthermore, by remaining proportionate to public health benefit it will be easier to retain the social license for these measures.
Overall	Given the limited effectiveness of this measure to quickly identify, test and isolate this person who has arrived from a given country, it is not considered proportionate to maintain post-arrival testing.	Given the limited benefit of maintaining post-arrival testing requirements, recommended border testing and the use of other surveillance approaches that reduce the burden on individuals is the preferred option.

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The COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand (including for air crew)

Option 1	Option 2
Maintain the COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand (including for air crew), noting the public health rationale is lesser than before. Currently new arrivals (who are not New Zealand citizens, residents or Australian citizens visiting New Zealand) are subject to requirements to be vaccinated with an approved vaccination.	Remove the vaccination requirement for arrivals from the COVID-19 Public Health Response (Air Border) Order 2021 and COVID-19 Public Health Response (Maritime Border) Order 2021

Public Health Risk Assessment process

PHRA recommendation	That vaccination requirements at the air and maritime border be removed as it is no longer justifiable. With Omicron, and the recognition that available vaccines are far less effective in reducing transmission, the current rationale is more about reducing the risk of severe illness, and the potential impact on the health system. Air carriers and maritime vessels can still require evidence of vaccination as a requirement of carriage if they so choose.

Multi-Criteria analysis

Criteria	**Option 1 (Status quo): Retain COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand (including for air crew), noting the public health rationale is lesser than this has been.**	**Option 2: Remove the vaccination requirement for arrivals from the COVID-19 Public Health Response (Air Border) Order 2021 and COVID-19 Public Health Response (Maritime Border) Order 2021**
s9(2)(h)		

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s9(2)(h)		if the requirement is reduced.
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	Likely to have a negative economic impact, unless the increase in travellers place an excessive burden on the health system.	+ Likely to have a positive economic impact with improved ease of travel for unvaccinated travellers
Equity- Evidence of the impacts of the measures for at risk populations	To date this has provided increased protection from severe illness and prevented hospitalisations however this risk is decreasing.	- This may lead to a small increase in cases.
Compliance- expected public compliance with measures	N/A- This is currently a requirement for entry and the other option is to remove the requirement.	
Overall	Given this measure serves a limited public health benefit, retaining it is unlikely to be tenable. Further consideration needs to be given to additional protections for at risk communities.	On balance, given the limited rationale for maintaining the measure, and that the vaccination requirement is no longer considered proportionate, this is the preferred option.

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The requirement for travellers to New Zealand not to exhibit symptoms or be under a public health direction

Options

Option 1	Option 2
Maintain requirement in the COVID-19 Public Health Response (Air Border) Order 2021 for arrivals to New Zealand to not exhibit COVID-19 symptoms on arrival or to be under a public health direction from another country.	Remove the requirement for arrivals to New Zealand to not exhibit COVID-19 symptoms on arrival or be under a public health direction from another country.

Public Health Risk Assessment

ODPH Recommendation *this has been considered by the Office of the Director of Public Health separately to the Public Health Risk Assessment	The Office of the Director of Public Health (ODPH) recommends that the requirement for travellers to New Zealand to not exhibit symptoms of COVID-19 and not be subject to a public health direction in another country is now removed. Given the current level of COVID-19 cases and hospitalisations in New Zealand, the decreasing strain on the health system, and that people may be pre-symptomatic or asymptomatic with COVID-19, there is no strong rationale for maintaining this requirement. We can instead revert to recommending that people who are unwell who don't travel, and the previous (pre-COVID-19) processes for dealing with passengers who display symptoms of being unwell[1].

Multi-criteria analysis

[1] This could involve airlines using their fitness to travel rules, and provisions within the Health Act 1956 which may include mandatory contact tracing, various types of mandatory directions and court orders, urgent public health orders to tain the person for 72 hours, and prosecution as a last resort. This is outlined here: https://www.health.govt.nz/system/files/documents/publications/guidance-infectious-disease-management-under-health-act-1956-feb17-v4.docx

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Criteria	Option 1: (Status quo) Maintain the requirement for arrivals to New Zealand to not exhibit COVID-19 symptoms on arrival or not be under a public health direction from another country	Option 2: Remove the requirement for arrivals to New Zealand to not exhibit COVID-19 symptoms on arrival or be under a public health direction from another country
s9(2)(h)		
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	Minimal social or economic benefit of this measure at this time	+/- Minimal social or economic benefit of removing this measure
Equity- Evidence of the impacts of the measures for at risk populations	No change	- Given the small increase in public health risk, removing the measure is likely to have a small increase in health risk for at risk populations. However, the use of previous (pre-COVID-19) processes for dealing with passengers who display symptoms of being unwell will reduce this risk.

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Compliance- expected public compliance with measures	In our current high trust-model, we would expect all people to follow any public health direction they may be under whether this is from another country or New Zealand. As there is no systematic way of verifying if a traveller is under a public health direction, this requirement is likely to be of little benefit. Airlines are also required to check the passenger compliance with all COVID-19 provisions, which may be undertaken at check-in or boarding, but is not systematic.	
Overall	Given the limited public health or compliance rationale, maintaining this requirement is unlikely to be proportionate.	+ Given the current level of COVID-19 cases and hospitalisations in New Zealand, the decreasing strain on the health system, and that people may be pre-symptomatic or asymptomatic with COVID-19, there is no strong rationale for maintaining this requirement. Furthermore, compliance challenges make strengthen the rationale for removing the measure.

. The requirement for household contacts to quarantine for 7 days

Options

Status quo	Option 1	Option 2
The requirement for household contacts to quarantine at home for 7 days is retained, to minimise the risk of household contacts who have not yet tested positive to spread COVID-19.	This requirement for self-isolation is removed and replaced with guidance that household contacts test daily for 5 days. Daily testing should commence from when the first case in the household tests positive (the public health recommendation).	The current requirement for mandatory self-isolation is removed and a mandatory requirement for testing on day 3 and day 5 replaces the current requirement for mandatory testing on day 3 and day 7

Public Health Risk Assessment summary

PHRA Recommendation	The public health advice is that the requirement for household contacts to quarantine for 7 day should be replaced with guidance to test daily for 5 days.

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	On the basis of proportionality, the current outbreak context, and overseas experience, daily testing of household contacts provides a sufficient risk mitigation if quarantine is removed. Daily testing rather than a 'test-to-leave' approach was favoured to support efforts to identify cases early. While removing household quarantine would increase cases, on balance it was marginal when considering the large impact quarantine itself was having on larger households especially, and wider society. Therefore, noting lead times and the outcome of consultation, we consider that now is the right time to remove the requirement. It is acknowledged that the modelled increases in case numbers and hospitalisations are expected to have a disproportionate impact on Māori, Pacific and other vulnerable communities who experience a higher burden of severe disease and may be more likely to work in jobs where they cannot work from home when unwell.

Multi-criteria analysis

Criteria	Status Quo – Self-isolation mandate (case & contacts)	Option 1: Guidance recommending daily testing for five days	Option 2: Mandatory testing on day 3 and day 5
s9(2)(h)			.

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Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	Status quo likely results in more total isolation days across the population than options that do not require household contacts to quarantine International evidence indicates that regulated mandatory requirements enable those who don't have access to sick pay or leave to be able to do so with their employers, unlike guidance. 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	+/- The likely overall impact is uncertain. Moving to voluntary 5-day testing would be likely to result in an increase in the number of cases, which would have negative economic and social impacts. However, reducing the level of self-isolation required from 7 to 5 days would have offsetting positive economic and social impacts as household contacts who do not contract the virus would be able to return to work or other activities earlier. Modelling earlier in 2022 indicated that 78% of household contacts became cases. Later modelling has used a figure of 60%, based on the likelihood that the rate of infection has dropped as Omicron moved into households with fewer people and relatively more living space.	+/- See comments for Option 1.
Equity- Evidence of the impacts of the measures for at risk populations	Compared to other options, this is likely to be the most effective in reducing the public health risk.	- The modelled increases in case numbers and hospitalisations are expected to have a disproportionate impact on Māori, Pacific and other vulnerable communities who experience a higher burden of severe disease and may be more likely to work in jobs where they cannot work from home when unwell.	- Older people, Māori, Pacific Peoples, and disability communities are likely to be disproportionately impacted by any decision to remove 7-day case isolation

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Compliance- expected public compliance with measures	Compliance with the measure currently is varying, based on the outcomes of waste water surveillance and survey evidence. An online survey in June found that 88% of respondents said they would follow self-isolation rules. It is likely that compliance would remain higher than options 1 and 2 Because some people are more likely to comply with a legally mandated requirement than to a voluntary requirement.	+/- Level of compliance is difficult to ascertain. Compliance would be supported by communications, and the provision of free Rapid Antigen Tests. The shift to a voluntary approach may be read as a signal that compliance is a lower government priority, leading to lower compliance than the status quo. On the other hand, the relatively low burden of compliance involved (taking a daily RAT) may mean that compliance remains at or near current levels	- Level of compliance is difficult to ascertain. Compliance would be supported by communications, and the provision of free Rapid Antigen Tests. The shift away from mandatory self-isolation may be read as a signal that compliance is a lower government priority, leading to lower compliance than the status quo. On the other hand, the relatively low burden of compliance involved (two mandatory RATs) may mean that compliance remains at or near current levels. This option presents issues of enforcement which may lead to lower compliance and effectiveness.
Overall		+ Preferred over the status quo and option 2, due to it being proportionate and still providing an effective public health response.	- Preferred over the status quo, due to it Representing a shift away from a mandatory approach to a voluntary approach supported by guidance being proportionate and still providing an effective public health response. Ranked after option 1 due to compliance issues discussed above.

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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. Removing 7-day case isolation while there is still a high degree of COVID-19 circulating around society risks prolonging the current COVID-19 outbreak, so that it is longer or more severe than necessary in its impact. There remains widespread support for retaining case isolation requirements from Medical Officers of Health and public health units throughout the country.

Multi-criteria assessment

Criteria	Option 1: (Status quo) retain 7-day self-isolation requirements for cases	Option 2: removing mandatory self-isolation for cases
s9(2)(h)		

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s9(2)(h) [redacted]	[redacted]	[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.	- Certain communities are likely to be disproportionately impacted by any decision to remove 7-day case isolation. In particular, before removing this measure it will be important to engage with these communities, including representatives of older people, Māori, Pacific Peoples, and disability communities.
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.

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Overall	Given the potential public health impacts, this remains effective, justifiable and proportionate at this time. It will be critical that this remains under constant review.	- Moving away from this approach at this time is likely to increase the public health risk and resulting impacts.

The COVID-19 Public Health Response (Vaccinations) Order 2021 which includes the vaccination mandates for health and disability sector workers

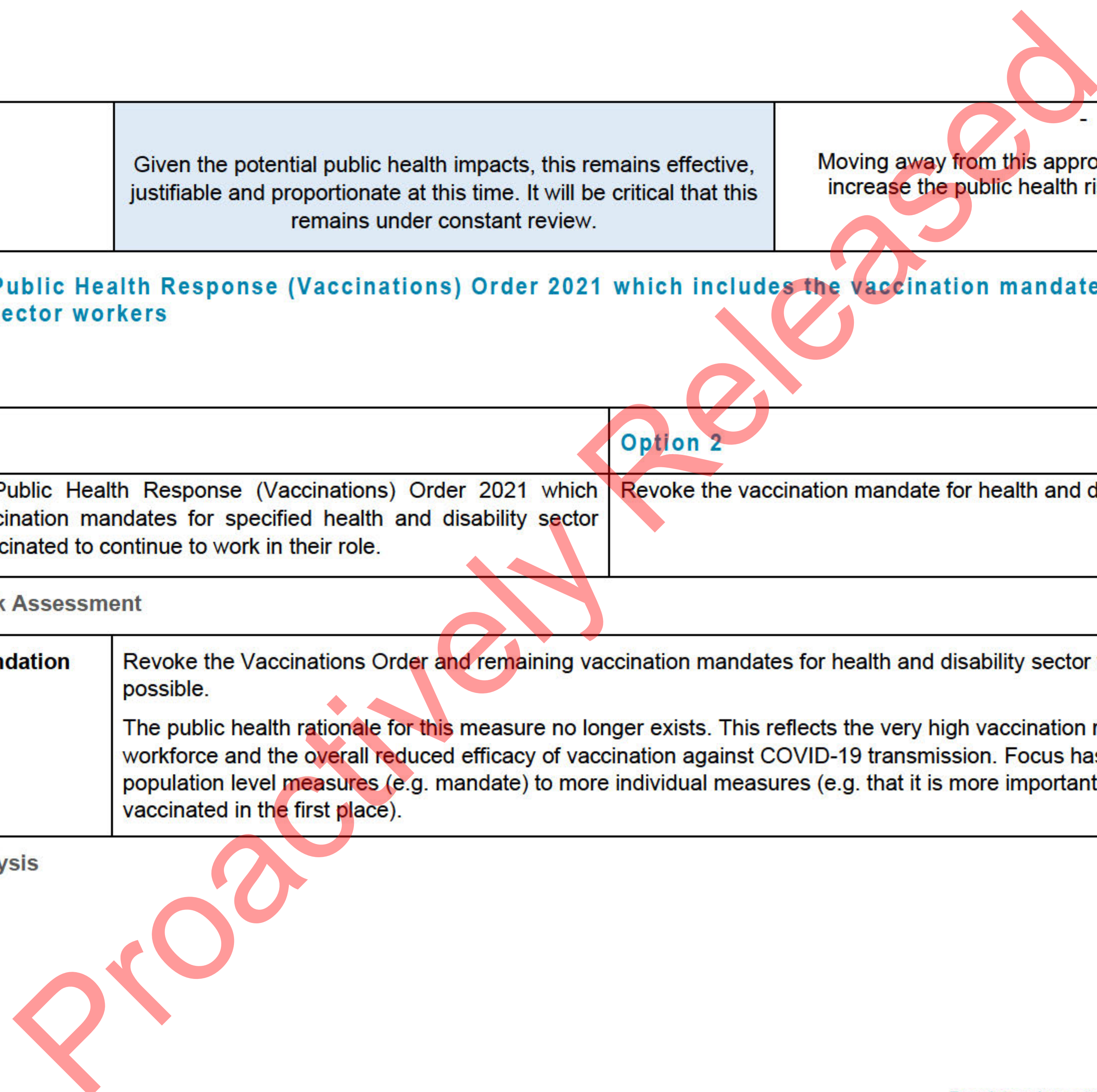
Options

Option 1	Option 2
The COVID-19 Public Health Response (Vaccinations) Order 2021 which includes the vaccination mandates for specified health and disability sector workers to be vaccinated to continue to work in their role.	Revoke the vaccination mandate for health and disability sector workers

Public Health Risk Assessment

PHRA recommendation	Revoke the Vaccinations Order and remaining vaccination mandates for health and disability sector workers as soon as possible. The public health rationale for this measure no longer exists. This reflects the very high vaccination rate among the affected workforce and the overall reduced efficacy of vaccination against COVID-19 transmission. Focus has also now shifted from population level measures (e.g. mandate) to more individual measures (e.g. that it is more important that patients are vaccinated in the first place).

Multi-criteria analysis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Criteria	Option 1: (Status quo) the COVID-19 Public Health Response (Vaccinations) Order 2021 which includes the vaccination mandates for health and disability sector workers remains in place	Option 2: Revoke the vaccination mandate for health and disability sector workers
s9(2)(h)		
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	The ongoing mandate may be preventing some people from entering the workforce.	+ This may be an opportunity for some unvaccinated people to re-join the health and aged care workforce, where there are not ongoing vaccination requirements through the Health and Safety at Work 2015 requirements.
Equity- Evidence of the impacts of the measures for at risk populations	given the limited ongoing public health benefit, it is unlikely to increase the public health risk for at risk populations	+/- given the limited ongoing public health benefit of the mandate, it is unlikely to increase the public health risk for at risk populations
Compliance- expected public compliance with measures	N/A	
Overall		+

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	Given that this measure currently is not supported by an ongoing public health rationale, retaining the mandate is no longer likely to be proportionate.	The proposed removal of this measure would be proportionate and not increase the public health risk.

6. Masking settings.

Options

Option 1	Option 2 (PHRA Proposal)	Option 3
Maintaining the requirement for mask use in many indoor settings and on public transport (i.e. CPF Orange settings) to reduce transmission.	Retain mask requirements on public transport and in healthcare settings (including aged residential care)	Mask guidance (no mandates)

Public Health Risk Assessment

PHRA recommendation	Retain mask requirements on public transport and in healthcare settings (including aged residential care) but remove mandates in other settings. Develop guidance to encourage ongoing use in other essential settings (e.g. supermarkets) like the approach with schools. This was considered an appropriate step-down option as we come out of winter and are reducing other requirements (e.g. household quarantine). Other essential services (e.g. supermarkets) have shown to be lower risk settings. While there was not support for removing all current mask mandates, there was support for considering options to reduce requirements where this was supported from a public health perspective.

Multi-criteria analysis

Criteria	**Option 1: Maintain the status quo for**	**Option 1 – Ongoing mask requirements in 'public transport' and 'healthcare settings'**	**Option 2 – Mask mandates are removed and replace with guidance**

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	Masks		
s9(2)(h)			
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		

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Equity- Evidence of the impacts of the measures for at risk populations	Current mask use provides effective protection for Māori, Pacific Peoples, disabled people and people living in areas of high deprivation	+/- Māori, Pacific Peoples, disabled people, and people living in areas of high deprivation are likely to be disproportionately affected if mask mandates were stepped down.	- Māori, Pacific People, Disabled people, and people living in areas of high deprivation are likely to be disproportionately affected if mask mandates were entirely removed and replaced with guidance.
Compliance- expected public compliance with measures	o	+ Survey respondents indicated a willingness to mask but social norms to masking were variable with signs of waning adherence in the status quo. Measures are most complied with and effective when people understand their rationale, and retaining mask requirements in essential close contact is commensurate with the reducing COVID-19 risk profile	- The evidence suggests adherence is higher when there is a mandate relative to guidance. Ongoing mask use is a highly useful "COVID legacy" but will require time to become a behavioural norm
Overall	o	+	-

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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.

The preferred option to remove several mandated public health measures at the border and reducing measures domestically may impact these priority populations. The proposal to reduce mandatory measures relies on established baseline measures being in place, which means maintain high vaccination rates, good public access to masks and rapid antigen tests (RATs) and improving access to antivirals for those most vulnerable to getting very unwell from COVID-19.

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:

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- 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, 86.6 percent of people are at least partially vaccinated and 56.1 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. This is further compounded by the severity of the 2022 flu season.

91.4 percent of Pacific peoples are at least partially vaccinated (compared to 91.5 percent across all ethnicities) and 60.8 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 and self-isolation changes will have an increased 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.

The proposal to remove the requirement that household contacts quarantine and instead complete daily RATs for 5 days may present an equity risk for disabled people and tāngata whaikaha Māori, who have difficulty in accessing testing resources. Whaikaha advise that extra support and strong communication is needed to ensure disabled people can meet this new requirement, including continuing to explore alternative testing modalities outside of RATs and PCR tests.

The removal of vaccination mandates, and reduced self-isolation requirements for household contacts will likely positively impact workforce capacity and therefore

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continuity of services. However, engagement with the disability sector raised the importance of ensuring disabled people and tāngata whaikaha Māori have choice and control over the vaccination status of their support workers.

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 will 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.

Transitioning from mandatory isolation of household contacts 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 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.

Given that the PHRA (supported by further analysis) recommends stepping down several mandated measures such as, 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[2], and COVID-19 and flu vaccinations.

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. This would support the removal of broad-based population requirements such as the CPF. 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

[2] In the week ending 24 July 2022, nine percent of antiviral courses went to Māori while they accounted for 10 percent of reported COVID-19 cases.

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hardship that requiring household contacts to isolate placed on many whānau, and that there will be some support for the removal of this requirement.

Further work will be needed to develop public health measures that will better 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, we propose to:

a. remove vaccination requirements, post-arrival testing requirements (replaced with recommendations to test), and requirements not to exhibit symptoms for arrivals;

b. retain requirements for air travellers to provide information for contact tracing purpose prior to departure;

c. remove all remaining vaccination mandates;

d. retain mandatory self-isolation of cases

e. retaining masks requirements on public transport and healthcare settings (including aged residential care)

f. replace self-isolation requirements for household contacts with guidance to test daily for five days;

For self-isolation for household contacts, two options are provided:

- Option 1: guidance only to test daily for 5 days for household contacts (our preferred option)

  or

- Option 2: mandatory day 3 and day 5 testing for household contacts.

The rationale for maintaining option 1 is proportionate and still providing an effective public health response.

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. Moving to the new strategy and adjusting mandated public health measures requires:

- Revoking the COVID-19 Protection Framework Order;
- Amending the Air Border Order;
- Amending or revoking the Maritime Border Order[3];
- Revoking the Vaccinations Order;
- Amending the Self-Isolation and Permitted Work Order; and

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[3] While the Air Border Order will continue to be required to provide for the preferred approach to retaining a requirement to provide contact tracing information, the Maritime Border Order will have no active public health requirements if the proposals in this RIA are accepted. Pending further considering, it's possible that giving affect to the proposals in this analysis will result in revocation of the Maritime Border Order.

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- Making a new mask order.

There are no changes proposed to the to the remaining Orders under the Act, being the COVID-19 Public Health Response (Isolation and Quarantine) Order 2020; 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 preferences.

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.

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 significantly disrupt essential governmental and business activity in New Zealand (or the parts of New Zealand concerned) significantly. It has been renewed by the Prime Minister every three months since the epidemic was first declared with the agreement of the Minister of Health and the Minister for COVID-19 Response and on recommendation of the Director-General of Health.

COVID-19 orders may only be made while the epidemic notice is in force, while a state of emergency or transition period in respect of COVID-19 under the Civil Defence Emergency Management Act 2002 is in force, or if the Prime Minister has authorised the use of COVID-19 orders, either generally or specifically.

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

The public health measures will remain under regular monitoring and review, with a proposal to review continued mandatory requirements through the Public Health Risk Assessment process s9(2)(f)(iv)

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Cabinet Social Wellbeing Committee

Minute of Decision

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Future of the COVID-19 Protection Framework and Moving to the New Approach

Portfolio **COVID-19 Response**

On 31 August 2022, the Cabinet Social Wellbeing Committee **referred** the submission under SWC-22-SUB-0159 to Cabinet on 5 September 2022 for further consideration, revised as appropriate in light of discussion at the meeting.

Rachel Clarke
Committee Secretary

Present:
Rt Hon Jacinda Ardern
Hon Grant Robertson
Hon Kelvin Davis
Hon Dr Megan Woods
Hon Chris Hipkins (Chair)
Hon Andrew Little
Hon Poto Williams
Hon Peeni Henare
Hon Jan Tinetti
Hon Kiri Allan
Hon Dr Ayesha Verrall
Hon Priyanca Radhakrishnan
Hon Aupito William Sio
Hon Meka Whaitiri

Officials present from:
Office of the Prime Minister
Department of the Prime Minister and Cabinet
Crown Law Office
Ministry of Health
New Zealand Customs Service
Officials' Committee for SWC

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Cabinet

Minute of Decision

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Future of the COVID-19 Protection Framework and Moving to the New Approach

Portfolio **COVID-19 Response**

On 5 September 2022, following reference from the Cabinet Social Wellbeing Committee (SWC), Cabinet:

1 **noted** that in July 2022, SWC agreed to a new COVID-19 strategy for post-winter 2022 and invited the Minister for COVID 19 Response to report back in August to advise on whether it is appropriate to revoke the COVID-19 Public Health Response (Protection Framework) Order 2021 (the COVID-19 Protection Framework Order) and move to the new strategy [SWC-22-MIN-0118];

2 **noted** that as part of the above decisions, SWC also agreed to the new approach of prepared, protective, resilient and stable to replace the minimise and protect strategy currently in place, which will be given effect through an approach of relying on baseline measures with more restrictive reserve measures kept for use in emergency circumstances;

3 **noted** that it is timely to remove the COVID-19 Protection Framework and move to the new approach, as we have well-established baseline measures, high vaccination rates and low case numbers, and consequently declining health system demand from COVID-19;

Transition to the new long-term approach to managing COVID-19

4 **agreed in principle**, subject to paragraph 11 below, to revoke the COVID-19 Protection Framework Order and thereby remove the COVID-19 Protection Framework;

Removal of measures

5 **noted** that on 17 August 2022 a public health risk assessment was held to assess the following COVID-19 measures that remain mandated:

5.1 air and maritime border requirements (including post-arrival testing, vaccination requirements for travellers and crew, provision of information);

5.2 vaccination mandates for health and disability workers;

5.3 isolation for cases and household contacts; and

5.4 mask requirements;

6 **noted** that the Director-General of Health recommended:

6.1 removing COVID-19 vaccination requirements, post-arrival COVID-19 testing requirements (replaced with recommendations to test), and requirements not to exhibit COVID-19 symptoms or be under a public health direction for arrivals;

6.2 retaining requirements for air travellers to provide information for contact tracing purposes prior to departure;

6.3 removing all remaining COVID-19 vaccination mandates;

6.4 retaining mandatory self-isolation of cases;

6.5 retaining mask requirements on public transport, including buses, commuter trains, domestic and international flights (arrivals), and in healthcare settings including hospitals, primary care, counselling, mental health and addiction, and aged residential care (at least communal areas and indoor facilities);

6.6 replacing self-isolation requirements for household contacts with guidance to test daily for five days;

7 **agreed in principle**, subject to paragraph 11 below, to:

7.1 remove COVID-19 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;

7.2 remove all remaining COVID-19 vaccination mandates; and

7.3 remove mandatory self-isolation of household contacts, to be replaced with guidance only to test daily for 5 days;

8 **noted** that the Director-General of Health will provide advice to the Prime Minister and other relevant Ministers prior to 15 September 2022, when the epidemic notice is due for renewal, on the legislative basis for ongoing COVID-19 restrictions;

9 **agreed in principle**, subject to confirmation of the legislative basis referred to in paragraph 8, to:

9.1 retain mandatory self-isolation of cases;

9.2 retain requirements for air travellers to provide information for contact tracing purposes prior to departure; and

9.3 retain masks in healthcare settings including primary care, urgent care, hospitals, aged residential care and disability-related residential care;

10 **agreed in principle**, subject to paragraph 11 below, to:

10.1 remove mask requirements on public transport (which includes buses, commuter trains, and domestic flights, but not international flights);

10.2 provide strong guidance on the wearing of masks on public transport;

11 **noted** that the above in-principle decisions are subject to Cabinet confirmation on 12 September 2022;

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12 s9(2)(f)(iv)

13 **noted** that the Minister for COVID-19 Response intends to implement the changes in paragraphs 7, 9, and 10 by:

13.1 amending or revoking the COVID-19 Public Health Response (Air Border) Order 2021 and the COVID-19 Public Health Response (Maritime Border) Order (No 2) 2020;

13.2 revoking the COVID-19 Public Health Response (Vaccinations) Order 2021;

13.3 amending the COVID-19 Public Health Response (Self-isolation Requirements and Permitted Work) Order 2022; and

13.4 making a new mask order that retains mask requirements in healthcare settings (including aged residential care) only;

14 **noted** that the mask order, like any order, can be amended quickly if needed to respond to an increase in COVID-19 risk, based on public health advice;

15 s9(2)(f)(iv)

16 **agreed** that the launch of the new approach and adjustments to mandated public health measures will be announced in the week of 12 September 2022;

17 **noted** that changes to domestic and border measures will be in place from 11.59pm on the day of announcement;

18 s9(2)(f)(iv)

Impacts on COVID-19 support schemes

19 **noted** that household contacts will no longer be eligible for the Leave Support Scheme if they are not legally required to self-isolate;

20 s9(2)(f)(iv) ;

21 **noted** that modifying isolation requirements for household contacts will reduce demand for Care in Community welfare response supports;

22 **noted** that Care in Community welfare programme is linked to self-isolation requirements to ensure that the programme is available to support low-income households to isolate safely and recover from impacts of COVID-19;

23 s9(2)(f)(iv)

Proactively Released

24 s9(2)(f)(iv)

Future legislative basis

25 **noted** that the Epidemic Preparedness (COVID-19) Notice 2020 (the epidemic notice) is due for review by 15 September 2022 at the latest;

26 s9(2)(h)

Processes for decisions on measures

29 **noted** that, to give effect to the new approach, clear processes will be used to review the measures in place and scale measures up or down when required, building on the processes that served New Zealand well in reviewing COVID-19 Protection Framework settings, with a focus on the health system;

30 **noted** that in addition to public health advice, advice on response measures will give consideration to the non-health factors previously agreed by Cabinet [CAB-22-MIN-0223; CAB-22-MIN-0114].

Rachel Hayward
Acting Secretary of the Cabinet

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