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

Proactive Release

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

COVID-19 Measures for Summer

The following documents have been included in this release:

Title of paper: COVID-19: Measures for Summer (SWC-22-SUB-0240 refers)

Title of paper: Regulatory Impact Statement: Proposed amendment to Self-Isolation Requirements Order 2022

Title of paper: COVID-19 Public Health Risk Assessment – 22 November 2022

Title of minute: COVID-19 Measures for Summer (SWC-22-MIN-0240 refers)

Title of minute: Report of the Cabinet Social Wellbeing Committee: Period Ended 9 December 2022 (CAB-22-MIN-0581)

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

Key to redaction codes:

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

~~In Confidence~~

Office of the Minister Hon Dr Ayesha Verrall
Minister for COVID-19 Response

Chair, Cabinet Social Wellbeing Committee

COVID-19: Measures for summer

Proposal

1 This paper seeks agreement to continue the current mandatory public health measures through the summer period, with some modifications. It notes what would happen if the COVID-19 risk changed significantly over the period.

Relation to Government priorities

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

Executive Summary

3 In October 2022, based on public health advice, Cabinet agreed to maintain seven-day case isolation and Government-mandated mask requirements for visitors to healthcare services [CAB-22-MIN-0443]. This decision was made in the context of emerging subvariants, rising case numbers, and on advice that New Zealand would likely experience a further wave by the end of 2022.

4 Although case numbers are increasing, the overall number of cases is lower than earlier in the year. The current seven-day rolling average of cases is 4,447.[1] This is 22 percent of the March peak, and 45 percent of the July peak. The increase is slow and steady at this stage, and pressure on hospitals from COVID-19 is markedly reduced (33 percent of the March peak, and 39 percent of the July peak). Therefore, I do not consider it appropriate now to escalate our COVID-19 response measures.

5 The Director-General of Health (the Director-General) and her team have completed a public health risk assessment based on the current context and recommended:

5.1 continuing with the existing mask requirements and case isolation

5.2 providing for permitted movements for COVID-19 cases to travel back to their home or primary residence by private means, active transport and/or by ferry if they test positive for COVID-19 while away from home.

6 I support both of these proposals.

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

[1] As of 1 December 2022.

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

9 The alternative of removing government-mandated requirements altogether and instead relying on guidance may send a signal to the population that there is less risk from COVID-19. This may in turn lead to a decrease in compliance with guidance. In the United Kingdom, there was a significant drop in adherence after the legal requirement to self-isolate was dropped in February 2022.

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

12 I will announce Cabinet's decisions on this paper during the week of 12 December 2022, before school holidays commence and many people begin travelling for the summer.

13 I propose that the remaining government-mandated measures will be reviewed again in early February 2023, unless there is a significant change in COVID-19 risk. Manatū Hauora will report back to COVID-19 Ministers with the results of that review

and any recommended changes to settings, and to Cabinet if major changes are proposed.

14 Should a variant of concern be identified over the summer, Manatū Hauora will assess its likely health impact in the New Zealand context. Consideration is needed for how any decisions to change settings will be taken. Depending on availability, Ministers could be delegated decision-making, should a change be needed over summer in response to significantly increased COVID-19 risk. As previously noted by Cabinet, the Director-General will alert the Duty Minister and/or COVID-19 Ministers if Manatū Hauora's assessment of the risk suggests severe adverse health outcomes are likely [CAB-22-MIN-0223].

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

Context

Status of the COVID-19 outbreak

16 As of the week ending 27 November, the 7-day rolling average of reported case rates was 73.8 per 100,000. This was an increase from the previous week, which was 65.6 per 100,000. This week rates were highest in the 25-44 age group, followed by 45-64 (86.2 and 81.7 per 100,000). The proportion of cases that were reinfections has increased this week, making up 24 percent of cases.

17 The COVID-19 hospital admissions rate decreased substantially from mid-July but increased since early October. In the week ending 20 November, the 7-day rolling average of hospital admissions was 1.4 per 100,000 population; which was a slight increase to the previous week (1.2). The rate was highest in the 65+ age group (4.6 per 100,000).

18 As of 27 November, there were 2,158 deaths attributed to COVID-19 in 2022. The weekly number of deaths attributed to COVID-19 has declined substantially since peaking early August, however mortality has been higher in November than in October.

19 BA.5 was the dominant subvariant accounting for an estimated 59 percent of cases, with the proportion of BA.5 declining slowly over the previous weeks. Detections of BA.2.75, BQ.1.1 are trending upward, both in WGS and wastewater. It is likely that over the next few weeks, cases, hospitalisations and mortality could increase. However, the size, timing, and duration of the peak and new baseline trends of cases, hospitalisations and mortality is currently uncertain.

20 Although case numbers are increasing, the overall number of cases is lower than earlier in the year. The current seven-day rolling average for cases[2] is 22 percent of the March peak, and 45 percent of the July peak. The increase is slow and steady at this stage, and pressure on hospitals from COVID-19 is markedly reduced (33

[2] The seven-day rolling average is 4,447 as of 1 December 2022.

percent of the March peak, and 39 percent of the July peak). Therefore, I do not consider it appropriate now to escalate our COVID-19 response measures.

Current measures

21 In October 2022, in the context of emerging subvariants and rising case numbers, Cabinet agreed to the following COVID-19 measures

21.1 Seven-day mandatory self-isolation for cases; and

21.2 Government-mandated mask requirements for visitors to healthcare services [CAB-22-MIN-0443].

22 The use of orders for these purposes is authorised by a COVID-19 Public Health Response (Authorisation of COVID-19 Orders) Notice 2022, issued by the Prime Minister under section 8(c) of the COVID-19 Public Health Response Act 2020.

23 This followed our decisions in September 2022 to remove the COVID-19 Protection Framework (the traffic lights), step down mask requirements and remove requirements for household contacts to self-isolate and for air arrivals to test. These requirements were replaced with guidance [CAB-22-MIN-0380].

24 A public health risk assessment was held on 22 November 2022 to review the remaining mandatory measures based on the current outbreak context and modelling (see Appendix One). The Director-General's recommendations as a result of that assessment are set out in this paper.

COVID-19 measures in place in other countries

25 I have previously advised on comparable case isolation requirements remaining in other countries, including Ireland, the Netherlands, and Singapore (which each have between three- and seven-day minimum isolation periods). Case isolation requirements were removed from the province of British Colombia, Canada, in November 2022 and Australia announced the removal of mandatory case isolation from 14 October 2022. A limited number of individuals in Australia are still able to access asset tested financial assistance to support case isolation. This support is restricted to casual workers in aged care, disability care, Aboriginal health care and hospital care with no sick leave entitlements.

26 While cases are increasing in New Zealand, they are increasing slower than in Australia. This is likely because of our continued mandatory case isolation, which reduces community transmission. At the beginning of October 2022, COVID-19 cases in New Zealand were starting to increase while cases in most Australian states were declining. The number of COVID-19 cases and hospitalisations across Australia have since increased as the country enters its fourth wave as a result of the relaxation of measures, new subvariants and waning immunity. Nationally, between 1 and 8 November, cases increased by 47 percent, with the largest increases observed in New South Wales and Victoria. The number of hospitalisations and ICU admissions across Australia have also increased by around 12 percent.

Factors for Cabinet to consider when reviewing mandatory measures

27 Cabinet has previously agreed several health and non-health factors to be considered when making decisions on mandatory COVID-19 measures [CAB-22-MIN-0223; CAB-22-MIN-0114; CAB-21-MIN-0421]. Health considerations are covered by the Director-General's advice in Appendix One.

28 The non-health factors are:

28.1 evidence of the effects of the measures on the economy and society more broadly;

28.2 evidence of the impacts of the measures for at-risk populations in particular;

28.3 public attitudes towards the measures and the extent to which people and businesses understand, accept, and abide by them;

28.4 our ability to operationalise the restrictions, including satisfactory implementation planning.

29 The following sections of the paper summarise the Director-General's advice and cover these factors for self-isolation and masks.

Self-isolation

30 Self-isolation requirements are set out in the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 (the Self-isolation Order). COVID-19 cases are required to isolate for seven days, starting from when their symptoms began or they tested positive, whichever came first.

31 Online guidance states that if you get COVID-19 while travelling you can drive home in a private or work vehicle. The guidance says that you cannot take a commercial flight home, do any long-distance road travel that requires an overnight stay or take an interisland ferry or public transport.

32 Under the current Self-isolation Order, once COVID-19 cases are at their place of self-isolation, they are not permitted to leave for the purpose of returning to their home to self-isolate (though they may change their place of self-isolation for limited reasons, including risk of harm, legal compulsion, or if isolating with a person more vulnerable to the impacts of COVID-19).

33 Officials have analysed three options for self-isolation for cases, including the addition of an extension to permitted movements:

33.1 Option One: Retain the status quo of seven-day mandatory self-isolation; or

33.2 Option Two: Retain the status quo of seven-day mandatory self-isolation, with an extension to permitted movements (Director-General recommendation); or

33.3 Option Three: Case isolation requirements are removed, and replaced with guidance.

Page 6 withheld in full under section 9(2)(g)(i) of the Act

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

[redacted]

[redacted]

[redacted]

[redacted]

Population and sector impacts

44 The Director-General notes that it is likely that removing case isolation would result in an increase in cases in some communities and population groups more than others. There is an acknowledged differential exposure to COVID-19 risk related to socioeconomic status. People in lower socioeconomic groups are more likely to work in jobs with greater risk of exposure, to live in larger and typically more crowded houses, and to have underlying risk factors. If there are more infectious people

circulating in a community with more baseline contacts, this increases the likelihood of onward transmission.

45 People who are socioeconomically deprived are more likely to face challenges in being able to isolate compared to people with greater access to socioeconomic benefits. This includes differing access to sick leave, and likelihood of income loss. Earlier return to work comes at the cost of increasing transmission, which is likely a more significant effect on health outcomes and ability to work due to illness. If the isolation mandate was removed, employees may be pressured to return to work even if not fully recovered. Equity concerns are central to this concern, particularly what this change might mean for Māori and Pacific communities.

46 Many sector and population agencies,[7] some iwi Māori leaders, and most Regional Leadership Groups (RLGs)[8] support retaining the seven-day case isolation period. Agencies noted that continuing self-isolation requirements may give reassurance to communities vulnerable to COVID-19. Some iwi Māori leaders reported increasing requests for support, preferring this measure is retained to reduce the spread and the burden on the existing systems. Agencies advised that if case isolation was removed, some people may choose to continue to self-isolate on a voluntary basis, as they do not feel they can safely participate in society.

47 Several agencies[9] and some RLG members noted that if case isolation is retained, employees and their whānau will require continued access to the COVID-19 Leave Support Scheme (LSS). This is particularly important for at-risk communities including Māori and Pacific employees and disabled people, who often work part-time roles, experience lower access to sick leave, and are at a greater risk of income loss if voluntarily self-isolating. This risk could be a driver for individuals not to report positive cases, or to return to work sooner (even if they are unwell). If case isolation and the supporting LSS schemes were removed, RLGs and MSD stated this would require some lead-in time to support front-facing staff and vulnerable and at-risk communities, so they could access food, housing and employment support from MSD where available and to avoid any service gaps during the transition.

48 While most agencies supported retention of mandatory case isolation, some noted that its removal may benefit businesses, including Māori, Pacific, ethnic and other small businesses. The Ministry for Ethnic Communities and some RLGs advised that some small business owners report staffing shortages due to staff being unwell, isolating, and unable to work, particularly within the hospitality industry. Some iwi Māori leaders and RLGs reported local resistance to government mandates and suggested that well communicated guidelines may be more effective.

49 Some iwi Māori leaders and agencies[10] support the proposed permitted movements to enable anyone who tests positive for COVID-19 while away to return home safely, or to encourage people to safely self-isolate in their accommodation if they can do so. MoE, the Ministry of Business, Innovation and Employment (MBIE) and some iwi Māori leaders noted there may be self-isolation issues for some international

[7] The Ministry for Pacific Peoples (MPP), Whaikaha – Ministry of Disabled People (Whaikaha), he Ministry for Ethnic Communities, he Ministry of Education (MoE), Te Arawhiti, Te Puni Kōkiri (TPK), the Ministry of Social Development (MSD), the Ministry of Housing and Urban Development, Oranga Tamariki, the New Zealand Police (Police), the Department of Corrections, National Iwi Chairs Forum (NICF) and the Office for Seniors.
[8] RLGs support social and economic recovery in each of the 16 regions. They consist of iwi, local government and community leaders who provide a regional voice on COVID-19 issues, and lead the Caring for Communities work. The composition of RLGs is determined by each region.
[9] The Ministry for Ethnic Communities, Whaikaha, Te Arawhiti, MPP and TPK.
[10] Te Arawhiti, Whaikaha, Police, Oranga Tamariki, MPP.

students, international tourists and whānau who cannot afford accommodation to self-isolate away from home, or while transiting home, which may require government support. RLGs advised that some tourism and accommodation providers may be uncomfortable with supporting travellers who become unwell with COVID-19 while travelling. TPK noted that tourism and hospitality sectors rely on people travelling to maintain customer volumes and income in summer.

50 Te Arawhiti and TPK support people using private transport but not public transport to travel to their home to isolate if they caught COVID-19 while away, with particular opposition to the use of ferries. Whaikaha and Police note that some people will not have access to a private vehicle. The Ministry of Transport (MoT), Te Arawhiti and MSD raised concerns about the assumption that people could use the outdoor area on ferries to distance themselves from other passengers. Concerns included not all ferries having outdoor areas, outdoor areas being closed during bad weather, or the outdoor area being unsafe for wheelchair users or people with respiratory issues.

Economic impacts

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

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

55 Institute of Environmental Science and Research (ESR) wastewater analysis, using an experimental (yet to be peer reviewed) estimate technique, suggests that 33 percent of infections [90% confidence interval 26%-41%] are now being reported as cases, down from over 65 percent in April. However, this analysis has not been adjusted for rainfall, which affects SARS-CoV-2 RNA concentration. In addition, asymptomatic people are unlikely to test and therefore be reported as cases, but their presence will be captured in wastewater testing results. For these reasons, Manatū Hauora advises that it would be inappropriate to use this figure as a proxy for adherence to self-isolation requirements.[11]

56 [Legally privileged] s9(2)(h) [redacted]

57 [Legally privileged] s9(2)(h) [redacted]

Self-isolation support schemes

58 The existing isolation requirements are supported by two schemes: the LSS and the CIC welfare response. LSS has a significant ongoing fiscal cost, while the CIC welfare response can be met within the current allocated funding, which is time-limited until the end of the financial year.

Leave Support Scheme (LSS)

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

[11] MoH COVID-19 Trends and Insights Report, 25 November 2022.

Care in the Community welfare response (CIC)

60 The CIC welfare response includes critical food support, Community Connectors, support for households with broader COVID-related issues, support for disabled communities, personal protective equipment (PPE) for at-risk communities, support for RLGs and accommodation through the National Alternative Accommodation Service (NAAS) provided by MBIE. Continuing these services over summer is vital to reducing the overall pressure and burden on the health system, as the use of CIC support and primary healthcare services diverts people from presenting at the emergency department.

61 s9(2)(f)(iv)

[redacted]

Masks

63 Mask requirements are set out in the COVID-19 Public Health Response (Masks) Order 2022 (the Masks Order). The Masks Order specifies that masks are legally required for visitors in a wide range of healthcare services including pharmacies.[12] There are exclusions for patients and people receiving residential care, health service staff, and visitors to specific health services (for example, psychotherapy, counselling, mental health, and addiction services). Requirements for patients and workers are determined by the health service, based on local assessments in line with Infection Prevention and Control guidance.

64 I recommend retaining the status quo, that is the government mandated mask requirements for visitors to certain healthcare services.

Public health advice

65 The Director-General recommends retaining mask requirements for visitors in health service settings. These mask requirements ensure that people who are at higher risk of severe illness can access healthcare in a relatively safe way without avoidable additional risk. A conservative estimate is that one in every six New Zealanders is at higher risk of severe illness if they contract COVID-19.[13]

[12] This includes primary care, urgent care, pharmacies, hospitals, aged residential care, disability-related residential care, and allied health, and other health service settings. Health service is defined very broadly – see the website for further details: https://covid19.govt.nz/prepare-and-stay-safe/protect-yourself-and-others-from-covid-19/face-masks/wearing-a-face-mask/.

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

66 Adherence to mask wearing requirements has been waning or inconsistent in some health service settings. I consider that it is highly likely that adherence would drop further if the mandate was removed.

s9(2)(g)(i)

Compliance

70 Several RLGs, some NICF members, and some iwi Māori leaders also note negative community attitudes, public apathy and pushback to the current remaining restrictions. There was some support for removing the remaining mask requirements and instead leaving it to individual choice and health organisations to determine their own requirements for visitors, as they do for patients and staff. Some regional leaders expressed that, as COVID-19 becomes endemic, people need to take their own preventative measures. RLGs, NICF members and some iwi Māori leaders suggested government-mandated measures are replaced with public health guidance as well as information about the level of risk so people can be well-informed in making their own decisions.

Economic impacts and operational considerations

71 The Treasury does not consider that current mask requirements have any measurable economic impact. Removing mandatory mask requirements may have a small negative economic impact insofar as removing the requirements would increase case numbers. There are no operational considerations to note.

Summer readiness

72 I expect the measures I have proposed in this paper will be adequate through the summer period. If the COVID-19 risk remains steady, the next review of mandated COVID-19 requirements will be in early February 2023. Manatū Hauora will report back to COVID-19 Ministers with the results of that review and any recommended changes to settings, and I will report to Cabinet if major changes are proposed.

73 Manatū Hauora conducted an All-of-Government National Readiness Group (NRG) exercise on 30 November 2022 to discuss readiness ahead of the summer season in case there is a serious increase in COVID-19 risk. Agencies in attendance agreed to review and update their readiness plans and discussed issues impacting any need for a system-level response over summer, including employee fatigue, access to funding and concerns around communication. The NRG discussed the expected increase in international visitors over summer, and related potential system impacts including on the health, border and accommodation sectors. A sub-group of the NRG with responsibilities in the tourism and border sector will meet to refresh plans from summer 2021/2022 and ensure they are fit for purpose.

74 Should a variant of concern be identified over the summer, Manatū Hauora will assess its likely health impact in the New Zealand context. The Director-General will alert the Duty Minister and/or COVID-19 Ministers if this assessment suggests severe adverse health outcomes are likely [CAB-22-MIN-0223]. Consideration is needed for how any decisions to change settings will be taken. Depending on availability, Ministers could be delegated decision-making, should a change be needed over summer in response to significantly increased COVID-19 risk. Any change in measures will be tailored to the characteristics of the variant of concern, and the community context in which it has seeded.

Consultation

75 This paper was prepared by DPMC's COVID-19 Group with review and input by Manatū Hauora, including advice on the course of the outbreak, the public health response, and the views and recommendations of the Director-General.

76 The following agencies were also consulted, and their views are reflected throughout this paper: Crown Law Office, 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, Ministry of Housing and Urban Development, Ministry of Justice, Ministry for Pacific Peoples, Ministry for Primary Industries, Ministry of Social Development, Ministry of Transport, Oranga Tamariki, Parliamentary Counsel Office, Police, Public Service Commission, Te Aka Whai Ora, Te Arawhiti, Te Puni Kōkiri, Te Whatu Ora, the Treasury, Whaikaha – Ministry of Disabled People, Office for Seniors.

77 DPMC also carried out engagement based on draft public health advice with members of the National Iwi Chairs Forum, other iwi Māori leaders, and Regional Leadership Groups. Their views are reflected throughout this paper.

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

Financial Implications

79 Financial implications have been included in relevant sections of the paper.

80 In the next week, Cabinet will also consider my proposal to draw-down the tagged contingency established in Budget 2022 to fund the COVID-19 Response into the 2023 calendar year. This proposal has been developed in consultation with the Minister of Finance and the Minister of Health, and if approved will provide the necessary funding to maintain an effective public health response to COVID-19 through to at least June 2023. Should Cabinet not agree to this funding proposal, there would be a need to consider what changes to public health settings would be necessary to further reduce the cost of the response.

Legislative Implications

81 If current settings for self-isolation and masks are retained, there are no legislative implications for the Self-isolation Order or the Masks Order. A change allowing COVID-19 cases to relocate between places of self-isolation would require an amendment to the Self-isolation Order.

82 It is also appropriate to maintain the regulation of RATs (point-of-care tests) while mandatory self-isolation requirements are in place. The importation, manufacture, supply, sale, packaging, and use of point of care tests is regulated under the COVID-19 Public Health Response (Point-of-care Tests) Order 2021. The purpose of this order is to ensure RATs, relied on to establish whether a person is subject to mandatory self-isolation, are accurate and reliable.

83 In October 2022, the COVID-19 Public Health Response (Authorisation of COVID-19 Orders) Notice 2022 came into force, by which the Prime Minister authorised the use of COVID-19 orders in relation to self-isolation requirements for COVID-19 cases, regulation of RATs (point-of-care tests), and mask requirements in health service premises. This notice expires on 20 January 2023. The Prime Minister will be receiving advice regarding the extension of the authorisation on 13 December 2022.

Impact Analysis

84 A Regulatory Impact Statement has been completed and is attached in Appendix Three. Manatū Hauora's Papers and Regulatory Committee has reviewed the attached Regulatory Impact Statement and considers that it partially meets the quality assurance criteria. The analysis is complete and reasonably convincing, particularly in the multi-criteria analysis, however, lacks clear Te Tiriti and equity analysis in the assessment of options. The document is difficult to read and there has been limited, insufficient consultation with Māori and other groups disproportionately affected by the pandemic.

Population Implications

85 As I have previously advised, the burden of COVID-19 does not fall equally, and changes to protective measures could disproportionately affect population groups such as older people, disabled people and tāngata whaikaha Māori, Māori, Pacific peoples and some ethnic communities.

86 In addition to views throughout the paper, the below table sets out how the current proposals impact specific population groups, based on agency feedback. For further information on population implications, refer to the Equity and Te Tiriti o Waitangi section of the Public Health Risk Assessment Memo at Appendix One.

Population group	How the proposal may affect this group
Older people	Retaining public health measures aimed at limiting the spread of COVID (such as masking or self-isolation requirements) will benefit older New Zealanders.
Disabled people and tāngata whaikaha Māori	For some disabled people, the reduction of COVID-19 protections during the Omicron outbreak has made them feel even more unsafe, with consequent impacts on behaviour and overall wellbeing. As a result, some disabled people and their whānau have decided that the safest option is to effectively self-isolate from the wider community to reduce their exposure to COVID-19. Retaining mandatory self-isolation will provide protection for disabled people and give disabled people the confidence to participate in activities outside their home. Whaikaha support targeted messages for disabled people regarding mask wearing in health service settings, as some disabled people have reported ongoing confusion regarding what 'health service settings' mean. Allowing positive cases to travel back to their home or primary residence by private means will enable disabled people to self-isolate in places with better access to their usual support services (including primary care and disability support services). Whaikaha noted that this may place people travelling by ferry at greater risk of contracting COVID-19 given other COVID-19 positive people may travel for this purpose. MSD noted that limiting transport to private means may have disproportionate impacts on disabled people who don't have access to or can't drive cars. s9(2)(g)(i) [redacted]
Māori	s9(2)(g)(i) [redacted]

	s9(2)(g)(i) [redacted]
Pacific peoples	The COVID-19 pandemic has exacerbated existing inequities for Pacific peoples, who have had the highest hospitalisation rates for COVID-19 and experienced mortality rates four times greater than European and other population groups. MPP advised that retaining self-isolation and existing masking requirements aligns with their strategic priority, *Pacific Aotearoa Lalanga Fou Goal 3: Resilient Health Communities.*
Other groups	*Corrections / Paiheretia* The prison population has a high rate of co-morbidities and a high proportion of Māori and Pacific people in custody, coupled with close living quarters and at some sites, poor ventilation, which make the prison environment a high-risk setting. Continuing the current self-isolation requirements supports Corrections to keep prison environments safer. TPK advised that any changes need to consider the individual needs of whānau who are engaged in the Corrections and wider justice systems. This includes challenges for whānau who are supporting and caring for others when a family member is incarcerated, or whānau members reintegrating following time in prison. TPK noted that there is limited or no support and resources for these people to better understand and comply with the requirements of COVID policies. Officials TPK and Corrections are meeting to discuss this issue. s9(2)(g)(i) [redacted]

Te Tiriti o Waitangi analysis

87 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. The active protection principle obliges the Crown to take all steps practicable to protect Māori health and wellbeing, and to support and resource Māori to protect their own health and wellbeing. This includes efforts to counteract inequitable health outcomes and prevent the impact of COVID-19 from falling disproportionately on Māori.

88 It is important for Māori communities to receive quick and clear communication about any changes to COVID measures, and be enabled to develop whānau and Māori-led community solutions to issues. TPK noted communities are also addressing the long-term impacts of COVID-19 including loss of incomes, loss of homes, mental health issues and managing the overall rise in living costs.

Human Rights [legally privileged]

s9(2)(h)

s9(2)(h) [redacted]

[redacted]

[redacted]

Communications

97 I will announce Cabinet's decisions on this paper during the week of 12 December, before school holidays commence and many people begin travelling for the summer.

Next steps

98 Unless there is an escalation in COVID-19 risk, as noted above, any remaining government-mandated measures will be reviewed again in early February 2023. Manatū Hauora will report back to COVID-19 Ministers on the results of that review, and to Cabinet if major changes are proposed.

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

Proactive Release

100 This paper will be proactively released following Cabinet consideration.

Recommendations

The Minister for COVID-19 Response recommends that the Committee:

1. note that since October 2022, we have had the following COVID-19 requirements in place:

1.1. Seven-day mandatory self-isolation for cases; and

1.2. Government-mandated mask requirements for visitors to certain healthcare services, including pharmacies but not counselling services;

2. note that there is an authorisation under 8(c) of the COVID-19 Public Health Response Act 2020 (the Act) in place to allow for the making of COVID-19 orders for self-isolation of cases and masks for visitors to health care settings until 20 January 2023, and that the Prime Minister will receive advice in mid-December on extending the expiry date beyond 20 January 2023;

Review of case isolation requirements

3. agree, for self-isolation of cases to retain the status quo of seven-day mandatory self-isolation (Director-General of Health recommended);

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

Review of government mandated mask requirements

5. agree to retain government mandated mask requirements for visitors to healthcare services;

Next steps

6. note that, to give effect to the above decisions, the Minister for COVID-19 Response will, if required, amend the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022;

7. note that decisions on this paper will be announced during the week of 12 December;

8. note that COVID-19 response settings will be reviewed again in early February 2023.

Authorised for lodgement

Hon Dr Ayesha Verrall
Minister for COVID-19 Response

Date:

Appendix One: Public Health Risk Assessment of COVID-19 mandated response measures, 25 November 2022

Appendix Two: Withheld under section 9(2)(g)(i) of the Act

Appendix Three: Regulatory Impact Statement: Proposed amendment to Self-Isolation Requirements Order 2022

Regulatory Impact Statement: Proposed amendment to Self-Isolation Requirements Order 2022

Coversheet

Purpose of Document	
Decision sought:	*Analysis produced for the purpose of informing:* a proposed amendment to the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022
Advising agencies:	*Manatū Hauora – Ministry of Health* *Department of the Prime Minister and Cabinet*
Proposing Ministers:	*Minister for COVID-19 Response*
Date finalised:	*Friday 2 December 2022*

Problem Definition

Under the Bill of Rights Act 1990 (BORA) and the COVID-19 Public Health Response Act 2020 (the COVID-19 Act), the Government has a responsibility to ensure its response to the COVID-19 pandemic remains effective, justified and proportionate. Public health risk assessments (PHRAs) carried out on 7 November 2022 and 22 November 2022 considered whether any changes are required to current COVID-19 policy settings. The PHRAs were based on recent data about trends in the impact of the pandemic on the community, including data for deaths and hospitalisations, and modelling of possible future developments.

Executive Summary

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

This Regulatory Impact Statement (RIS) sets out the information and analysis which informs proposed changes to the legal framework for managing the COVID-19 pandemic. The framework is established under the COVID-19 Act. Specific requirements are set out in the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 (the Self-isolation Order) and the COVID-19 Public Health Response (Masks) Order 2022 (the Masks Order), both of which are made under the COVID-19 Act.

The Self-isolation Order establishes the requirement that COVID-19 cases (cases) self-isolate. This requirement is qualified by provisions which enable cases to leave their place of self-isolation to carry out high priority activities under highly restrictive conditions. These conditions include strict infection prevention and control (IPC) measures.

The Masks Order establishes the requirement that people visiting healthcare services wear face masks.

The RIS draws on analysis including:

- information from the PHRA process
- detailed assessment of options against the criteria for the ongoing strategic approach

- Te Tiriti o Waitangi analysis, and Equity analysis.

The PHRA recommended that mandatory self-isolation for COVID-19 cases (cases) be retained. Isolation of cases remains the cornerstone of New Zealand's public health response to COVID-19. It significantly limits the transmission of COVID-19 by reducing the proportion of cases infecting others in the community. Further it was assessed that this measure is more effective than other less restrictive measures in combination. Specifically face masks or physical distancing are less effective while a shorter isolation period (with test to release) isn't considered a viable alternative.

Without government mandated isolation for cases, it is highly likely that adherence to guidance would be lower, resulting in an overall increase in transmission and case rates: increasing the risks of serious illness and hospitalisation for Māori, Pacific people, older people and people with disabilities (among other higher risk groups), and increasing pressures on the health system. Overseas evidence suggests that a legal requirement to isolate results in significantly greater adherence than a recommendation to isolate. Experience when other mandates (e.g., masks) have been removed in New Zealand suggests that adherence to guidance is typically much lower than to mandates.

s9(2)(g)(i)

[redacted]

Analysis presented in this RIS supports the recommendations of the PHRA.

Equity and Te Tiriti o Waitangi analysis support retaining mandatory self-isolation for cases. Health outcomes from COVID-19 for vulnerable populations, including Māori, remain disproportionately high by comparison with the wider population. Shifting from mandatory to voluntary self-isolation would be highly likely to result in an increase in the number of cases, with the consequence of a disproportionate negative impact on health outcomes for vulnerable populations.

Implementation, monitoring and review

Where changes are required, they are readily implementable through order changes and supporting public health initiatives.

The new measure would remain under regular monitoring and review, including through regular Public Health Risk Assessments.

Limitations and Constraints on Analysis

This proposal is subject to a number of limitations:

- limited time to prepare this Regulatory Impact Statement
- data from modelling results are subject to significant uncertainty around the impact of policy changes, the level of immunity in the population and population behaviour
- limited time for detailed equity and Te Tiriti o Waitangi analysis, and due to timeframes and sensitivity, wider engagement has not been possible. Current measures, which are recommended to be retained, have been engaged on in previous PHRAs.

- time constraints affecting the level of stakeholder engagement.

These limitations are acknowledged. However, the PHRA provides a robust process for consideration of proposed public health changes at pace. It draws on public health, policy, legal, operations and Māori health expertise, as well as detailed data and evidence. These sources are supported by further stakeholder engagement, primarily conducted by the Department of the Prime Minister and Cabinet (DPMC) and are set out in the Cabinet paper.

Responsible Manager(s) (completed by relevant manager)
Alice Hume *Head of Strategy and Policy* *COVID-19 Group* *Department of the Prime Minister and Cabinet*  *2 December 2022*
Stephen Glover *Group Manager, COVID-19 Policy* *Strategy, Policy and Legislation* *Manatū Hauora*  *2 December 2022*

Quality Assurance (completed by QA panel)	
Reviewing Agency:	Manatū Hauora
Panel Assessment & Comment:	The Ministry of Health's Papers and Regulatory Committee has reviewed the attached Regulatory Impact Statement and considers that it partially meets the quality assurance criteria. The analysis is complete and reasonably convincing, particularly in the multi-criteria analysis, however lacks clear Te Tiriti and equity analysis in the assessment of options. The document is difficult to read and there has been limited, insufficient consultation with Māori and other groups disproportionately affected by the pandemic.

Section 1: Diagnosing the policy problem

Context behind the policy problem

Under the BORA and the COVID-19 Act, the Government has a responsibility to ensure its response to the COVID-19 pandemic remains effective, justified and proportionate.

PHRAs carried out on 7 November 2022 and 22 November 2022 considered whether any changes are required to current COVID-19 policy settings. The measures in question are established by the Self-isolation Order and the Masks Order.

The PHRAs were based on recent data about the progress of the pandemic and modelling of likely future developments and on input from community sources.

How is the status quo expected to develop?

Overall, the key measures of COVID-19 infection (levels of viral RNA in wastewater and reported case rates) used to monitor the pandemic are stabilising, after substantially increasing since early October 2022.

Hospital admission rates increased over October 2022, while mortality counts have remained stable. However, in the past two weeks hospital admissions have also stabilised.

Experience to date shows that these measures tend to lag changes in infection rates. The current trends are likely to be influenced by a combination of:

i. waning immunity (vaccination and infection-induced immunity)
ii. behavioural changes associated with the relaxation of previous requirements, greater social interactions, and lower adherence with public health guidance
iii. the impact of new sub-variants.

It is likely that over the next few weeks, cases, hospitalisations and mortality could increase. However, the size, timing, and duration of the peak and new baseline trends of cases, hospitalisations and mortality is uncertain.
Australia is experiencing a wave of cases that may peak in the next few weeks. If New Zealand follows suit, as has occurred in the past and usually within a few weeks, we may see cases increase once more. However, there is significant uncertainty in predicting case and hospital trends.

What is the policy problem or opportunity?

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

In October 2022, Cabinet decided to retain Government-mandated seven-day isolation for cases and mask requirements for visitors to healthcare services. This decision was made in the context of emerging subvariants and rising case numbers, suggesting that New Zealand would likely experience a further wave by the end of 2022.

As noted above, there is significant uncertainty when predicting case and hospital trends. However, recent data and modelling suggests that there continues to be a realistic risk that we will see cases increase from November 2022 levels.

A further consideration is that we are approaching the summer holiday season. This will present particular challenges from the point of view of limiting the spread of COVID-19, as people leave their homes to go on holiday, in many cases to remote or rural locations.

The broad policy choice for the Government at present is whether strong guidance or government-mandated measures are the best way to encourage public health behaviour that

minimise the spread of the virus. Under the COVID-19 Act, public health advice must be considered in making this choice, but Ministers may also consider social, economic and other factors.

Based on preliminary analysis, the practical choices arising out of the November PHRAs have been narrowed down to the following:

* Retain the status quo of mandatory 7-day isolation for cases; or

* Retain the status quo and add a new permitted movement which would allow cases to travel home to isolate); or

* Remove mandatory isolation for cases and move to guidance only for cases.

s9(2)(g)(i)

[redacted]

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?

Stakeholders

The ongoing response to COVID-19 affects everyone in Aotearoa New Zealand. However certain groups are more at risk due to clinical or equity-based reasons (discussed further 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, members of the National Iwi Chairs Forum (NICF) and the Regional Leadership Groups (RLGs).

Public Health Risk Assessment

Officials from Whaikaha and Te Aka Whai Ora contributed the vulnerable group perspectives through the PHRA process. Officials were able to draw on community views in making representations over the course of the PHRA.

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

Iwi Māori leaders reported local resistance to mandated requirements, and NICF and iwi Māori leaders suggested that well communicated guidelines may be more effective. NICF members stressed the importance of communication being simple, clear and straightforward to whānau and led by Māori where possible.

Regional Leadership Groups (RLGs)

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

RLGs had mixed views on retaining or reducing case isolation though broadly supported retaining seven-day isolation for people with COVID-19. Regional leaders provided split feedback, with the business community noting likely compliance challenges for infected visitors over summer and more broadly raising the possibility for a transition to an endemic management approach; while Iwi, community, government (central and local) leaders largely support the status quo or expanding it, emphasizing people's ongoing clinical or employment vulnerability or health system capacity concerns.

RLGs noted that COVID cases, hospitalisations, and deaths are increasing, with a possibility of a spike in cases over summer as people begin to travel inter-regionally. Continuing mandatory self-isolation requirements could help to reduce the spread, and reduce the burden on hospital and regional medical services who are stretched, or may have reduced to skeleton staff over the holiday period particularly in popular holiday destinations like Te Tai Tokerau and Queenstown Lakes.

RLGs have advised that some small business owners report that staffing shortages due to staff being unwell, isolating and unable to work, particularly within the hospitality industry remains a concern. Otago and Southland RLGs report that the tourism sector has concerns around travellers who test COVID positive that may be unable to self-isolate in place. It is understood that some accommodation and transport providers have expressed a reluctance to support travellers who become unwell with COVID-19 while travelling.

However, RLGs also note negative community attitudes, public apathy and pushback to remaining restrictions. Some RLGs provided anecdotal evidence that there is local resistance to existing restrictions in place, with some people reluctant to test and to self-isolate as it will impact their ability to operate their businesses.

If cases are no longer required to isolate, RLGs suggested that guidance could be provided to encourage those who are unwell to test and stay home if positive on a voluntary basis. Some regional leaders expressed that, as COVID-19 become endemic, people need to take their own preventative measures, suggesting a removal of government-mandated measures. Any removal of mandatory measures should be accompanied by guidance on voluntary, protective measures and good public health behaviour, as well as information about the level of risk so people can be well-informed in making their own decisions.

Transport

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

Vulnerable populations

The burden of COVID-19 does not fall equally, and changes to protection measures could disproportionately affect population groups such as older people, disabled people and tāngata whaikaha Māori, Māori, Pacific peoples and some ethnic communities. At a high level, population agencies have noted that

- retaining public health measures aimed at limiting the spread of COVID (such as masking or self-isolation requirements) will benefit older New Zealanders. Case isolation requirements remain the most effective measure to reducing transmission of COVID-19 and therefore reducing inequities.
- disabled people and tāngata whaikaha Māori have experienced an exacerbation of existing inequities throughout the COVID-19 pandemic. Retaining mandatory self-isolation provides protection for disabled people and give disabled people the confidence to participate in activities outside their home.
- continued self-isolation requirements alongside other supports for Māori including access to sick leave and sanitation supplies to prevent further transmission in households.
- retaining self-isolation aligns with their strategic priority, Pacific Aotearoa Lalanga Fou Goal 3: Resilient Health Communities.
- any changes need to consider the individual needs of whānau who are engaged in the Corrections and wider justice systems.

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

Across the health system, Māori and Pacific peoples are more at risk of negative health outcomes than other population groups on an age-comparable basis, and are also more likely to experience greater disease exposure. Similarly, those experiencing socio-economic disadvantage are at greater risk of severe negative health outcomes than other people of the same age, and are also more likely to experience greater disease exposure.[1]

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

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

Given the broad implications of COVID-19 requirements and consistent with the requirements in the COVID-19 Public Health Response Act 2020, we need to consider public health implications, BORA implications and Te Tiriti o Waitangi and equity implications.

s9(2)(h) [redacted]

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

s9(2)(h)

[redacted]

[redacted]

Outline the key assumptions underlying your understanding of the problem

The key assumptions underlying the approach to the problem taken in this RIS:

- The Government has a legal responsibility to manage the response to COVID-19, within the framework established by the COVID-19 Act and BORA considerations.
- The Government has a legal responsibility to ensure that the response to the pandemic is effective, justified and proportionate.
- In carrying out its legal responsibility, the Government must take account of public health advice, and may take account of other relevant social and economic considerations.

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 Act, and other related requirements, we have identified the following criteria.

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

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

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

Compliance - expected public compliance with measures (noting that this would only be used where compliance is relevant - 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 aligned to the criteria for the new strategic approach. We note that implementation considerations are being considered separately, in Section 3 below.

What scope will options be considered within?

Options are considered within the scope of:

a) The Government's responsibility to manage the response to COVID-19, within the framework established by the COVID-19 Act (including BORA considerations).
b) The current context of the pandemic, as identified by public health analysis and advice.
c) Other social and economic considerations relevant to the Government's response to COVID-19.
d) The current legislative framework for the Government's response to COVID-19, although modifying the framework remains an option.

Analysing the proposals

Proposals for different options for each of the measures considered are included below, together with analysis, including public health advice and multi-criteria assessment.

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

The proposals are withheld in full under section 9(2)(f)(iv) of the Act

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

Equity analysis

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

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

Reducing mandated public health measures may lessen the impact of public health measures on choice, economic stability and experience of inequity due to enforcement systems. However, it has the potential to increase the inequity associated with co-morbidities or other health conditions that exacerbate the effect of contracting the virus, for example leading to self-imposed isolation, or an increased chance of hospitalisation or needing medical intervention.

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.

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.

Among Māori, 86.8 percent are at least partially vaccinated, and 56.3 percent of Māori who are 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.

Māori continue to have the one of the highest hospitalisation rates compared to other ethnicities, after standardising by age. COVID-19 attributed mortality rates are also higher 1.9 times higher among Māori, compared to European and other ethnicities. Modelling predicts that the mid-December 2022 peak will see 1800 daily new cases among Māori. It also indicates that during the peak there may be 30 Māori hospital admissions per day.

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 that Pacific Peoples are significantly overrepresented in all of the negative COVID-19 health statistics.

Among Pacific Peoples, 91.7 percent are at least partially vaccinated (compared to 91.5 percent across all ethnicities) and 61.2 percent of eligible Pacific peoples have received at

least one booster dose (compared to 73.1 percent across all ethnicities). There is more work to be done in encouraging booster vaccination uptake among Pacific peoples to mitigate the impact of the predicted rise in case numbers over the summer.

Pacific peoples continue to have the highest hospitalisation rate compared to other ethnicities, after standardising by age. In the week ending 23 October 2022, age-standardised rates for hospitalisation for COVID-19 decreased for all ethnicities except Pacific peoples. COVID-19 attributed mortality rates are also 2.4 times higher among Pasifika, when compared to European and other ethnicities.

Modelling predicts that the mid-December 2022 peak will see 800-900 daily new cases among Pacific Peoples. It also indicates that during the peak there may be 15 Pacific Peoples hospital admissions per day.

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. Opting to remove mandatory case self-isolation will cause lasting health issues and death for older people who fall ill due to the increased transmission resulting from cases ignoring self-isolation guidance. Opting against reinstating mask requirements on public transport will impact on the health of those amongst this group, particularly as many older people rely on public transport for essential travel.

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.

s9(2)(f)(iv)

The continuation of measures, particularly face masks requirements for people accessing medical services, provides people with disabilities some, albeit little, reassurance. The absence of mask requirements in environments such as public transport causes anxiety and additional risk for disabled people, particularly those with underlying co-morbidities.

Equity analysis for other/all groups

The most deprived populations continue to have the highest rates of hospitalisation, and have twice the risk of hospitalisation, compared with those who are least deprived. 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.

Broadening the essential permitted movement of cases to allow them to return to their primary place of residence will enable cases visiting family living in crowded housing to return home to isolate and protect their vulnerable family members. It also eases the monetary burden on those who are most deprived who would otherwise be forced to pay for additional accommodation so that they can complete their self-isolation in situ.

Retaining the 7-day self-isolation period ensures that cases belonging to vulnerable groups, who may otherwise face pressure or coercion from their employers to return to work, can refer to the mandated self-isolation period as a reason they cannot leave isolation. This allows them to rest and recover, which reduces the immediate and long-term health impacts of their infection. It also prevents the case from infecting family, friends and colleagues, who may also belong to vulnerable groups. On the other hand, there are some equity concerns that retaining mandated 7-day isolation prevents people in high-deprivation from returning to work and earning money, and further, that this may jeopardise their employment.

Removing mandatory case self-isolation and switching to isolation guidance only would result in much lower compliance with self-isolation advice. Long-term COVID-19 sequelae and Long COVID, which disproportionately impacts vulnerable groups such as Māori, Pacific Peoples and people with disabilities, would increase as cases do not rest and recover when they are ill. Transmission would increase, putting vulnerable populations at even greater risk than they face under the status quo settings. Removing mandatory self-isolation, however, represents a significant reduction of rights-limiting measures imposed on cases, but in the current context these limitations are justified.

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 states that Te Tiriti obliges the Crown to commit to achieving equitable health outcomes for Māori, and that doing so only along with commitments regarding other ethnicities is insufficient; specific focus must be granted to achieving equitable outcomes for Māori. The report found that the Government was failing to meet Te Tiriti obligations, in particular with the rollout of the vaccinations programme, and that this failure would result in disproportionate and lasting impacts of Long COVID on Māori.

As Māori continue to be overrepresented among daily cases, and modelling predicts 1800 daily new cases among Māori during the mid-December peak, the Māori Protection Plan's two key drivers are critical. Response initiatives should continue to have a positive impact for Māori, including the ongoing Winter Package measures. This includes as free medical and N95 masks, greater access to antivirals for those that are eligible by prioritising equitable access for Māori alongside other eligibility criteria, and COVID-19 and flu vaccinations.

Targeted engagement has been undertaken with Māori stakeholders on the changes being assessed in this regulatory impact statement: with the National Iwi Charis Forum, representatives of non-affiliated iwi and Māori leaders who are part of RLGs. In addition, Māori health representatives taking part in the 22 November 2022 PHRA expressed strong support for each of the changes assessed in this regulatory impact statement. This excludes the proposed removal of mandatory case self-isolation, as this was not discussed in the PHRA. They noted that while expanding essential permitted movements for cases may increase transmission, which disproportionately impacts Māori, it would also allow Māori to access the goods that they require in order to isolate safely. s9(2)(g)(i) [redacted]

s9(2)(g)(i)

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 health inequity resulting from COVID-19. 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?

The overall assessment arrived at through the analysis presented in this RIS supports the following recommendations:

a) Retain mandatory self-isolation for COVID-19 cases.
b) COVID-19 cases who become infected while travelling should be permitted to return to their home or primary residence.

Section 3: Delivering an option

How will the new arrangements be implemented?

Introducing a new permitted movement would require an amendment to the Self-isolation Order.

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

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

Changes to policy settings would also have direct impacts on the quantum of funding required to deliver the associated activities. It is noted that a separate paper addressing the funding required to deliver these settings, and related health services, is due to be considered as a companion to the Cabinet paper to which this RIS relates.

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

As noted above, the Government is required under the COVID-19 Act to monitor and review mandatory public health measures. This includes monitoring of case numbers, hospitalisations, international trends to identify variants of concern, along with wastewater and other surveillance activities. Trends in case numbers, hospitalisations and mortalities are compared by ethnicity and deprivation. The results of this monitoring and surveillance is compiled into a weekly insights report (as well as other ad hoc reporting) to help inform decision making.

A further PHRA is planned for January 2023. The Minister for COVID-19 Response will report to Cabinet on the results of that review and any proposed changes to settings.

Memo

COVID-19 Public Health Risk Assessment – 22 November 2022

Date:	25 November 2022
To:	Dr Diana Sarfati, Director-General of Health, Manatū Hauora
From:	Dr Nicholas Jones, Director of Public Health, Public Health Agency, Manatū Hauora
Copy to:	Dr Andrew Old, Deputy Director-General, Public Health Agency, Manatū Hauora
For your:	Information and decision

Purpose of report

1. This memo provides advice from the Director of Public Health following the 22 November 2022 COVID-19 public health risk assessment (PHRA) that considered whether any changes are required to COVID-19 settings and other matters based on the current outbreak context and modelling.

2. This memo builds on, and provides further clarification of, the recommendations developed following the PHRA on 7 November 2022.

Summary of Director of Public Health recommendations

3. s9(2)(f)(iv)

[redacted]	[redacted]
Face masks	**Retain** the current face mask mandate for visitors[1] in health service settings.

	s9(2)(f)(iv) [redacted]
Case isolation	**Retain** the 7-day case isolation requirement, with further review at the next PHRA.

4. These recommendations are consistent with the advice following the 7 November PHRA on face masks but provide suggested modifications to the essential permitted movement recommendations. This aims to ensure the overall approach remains a cohesive and pragmatic package to encourage and support public health behaviours needed to reduce transmission and the impact of COVID-19.

Background and context

High-level summary of the outbreak status and epi-context

5. Overall, reported case rates are continuing to increase albeit more slowly, after substantially increasing since early October. Wastewater trends that tend to monitor underlying infection have stabilised recently.

6. Hospital admission rates increased over October 2022, while mortality counts have remained stable. However, in the past two weeks hospital admissions have also stabilised.

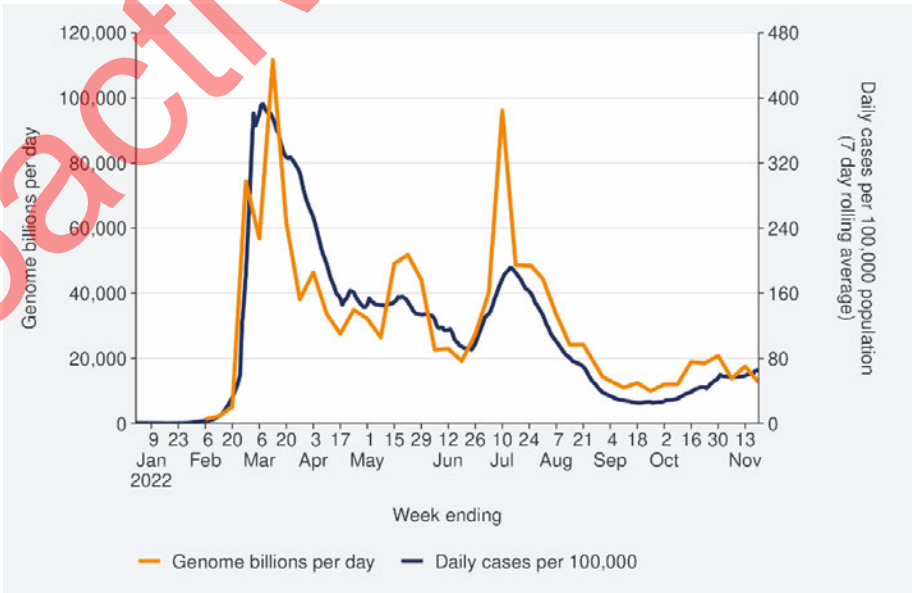
7. Experience to-date shows that these measures tend to lag changes in infection rates. The current trends are likely to be influenced by a combination of:

   a. waning immunity (vaccination and infection-induced immunity)

   b. behavioural changes associated with the relaxation of previous requirements, greater social interactions, and lower adherence with public health guidance

   c. the impact of new sub-variants.

Figure 1 - COVID-19 wastewater detection levels and daily case rates 2022 through 30 November 2022



8. Future movement of cases remains difficult to predict. Given Australia is experiencing a wave of cases that may peak in the next few weeks, if New Zealand repeats this pattern, as has occurred in the past usually within a few weeks, then cases may increase once more.

However, there is significant uncertainty when predicting case and hospital trends. A summary of the latest data is provided below, with outbreak and epidemiological-context detail in Appendix 1, and updated modelling in Appendix 2. COVID-19 data on priority populations is summarised in later sections (paragraph 27)and in Appendix 1.

Reported cases and wastewater detections

9. Reported case rates have increased by 16% from the week ending 6 November (57 per 100,000) compared to 20 November 2022 (66 per 100,000).

10. Wastewater trends have increased since early October but have stabilised in the past few weeks. However, it could be that recent trends have been affected by heavy rain across the motu.

11. The proportion of cases that were reinfections has also been increasing since the week ending 6 November (15% of cases) to the week ending 20 November (20% of cases). This suggests the current wave is at least partially arising from waning immunity and the introduction of immune evasive subvariants.

Whole genome sequencing and expected impacts of new subvariants

12. The following genomic data pertains to the period 29 October to 11 November. BA.5 remains the dominant subvariant accounting for an estimated 66% of cases. The proportion of BA.5 has been declining slowly over the previous weeks, as detections of BA.2.75 (currently 13%) and BQ.1.1 (currently 10%) are trending upward, both in whole genome sequencing (WGS) and wastewater. XBB currently makes up 3% of detected cases and is also trending upwards in wastewater. ESR reporting shows that BQ.1.1, XBB and BA.2.75 variants are over-represented in reinfections, albeit with very small sample sizes. Although the impact of these variants on the New Zealand population is not yet known, international experience suggests the emergence of these variants will increase baseline levels of transmission with an increase in cases and the potential resulting small to moderate waves over the coming months.

13. Eight cases of XBC have been identified in the most recent WGS report for the fortnight ending 11 November. XBC is a recombinant lineage that is a combination of Delta and Omicron. XBC has been present in Australia and Southeast Asia and has no indication of increased disease severity. None of the cases detected in New Zealand were listed as being hospitalised.

14. BQ.1.1 is stalling in frequency overseas and this is likely due to the emergence of further variants that are competing with BQ.1.1. International data suggests a limited impact on hospitalisations due to lower realised severity and multiple layers of immunity in the population. BQ.1.1, XBB and BA.2.75 variants all have evidence of a growth advantage compared to BA.5. There is no evidence of a change in severity compared to BA.5 for these variants. BA.2.75 subvariants have also seen growth in recent weeks to 13% of all sequenced samples for the week ending 11 November. The growth of BA.2.75 in New Zealand in October and November may be driven by an increase of CH.1.1 (46% of BA.2.75 cases in week ending 11 November).

Hospitalisations

15. The national COVID-19 hospital admissions rate 'for' COVID-19 decreased substantially from mid-July to mid-September 2022 increasing again in October. However, rates have recently stabilised to 1.2 per 100,000 compared to 1.3 per 100,000 in week ending 06 November 2022. Modelling scenarios suggest current hospital admissions are tracking

above the higher range of the prediction and it is too early to tell if the decrease is a temporary plateau.

16. Internationally, the BQ.1.1 wave of cases in Europe has, in general, not been associated with a substantial increase in hospitalisations 'for' COVID-19. This is a measure of the 'realised' severity, given the various layers of immunity in the populations (vaccine and prior infection) along with the use of antivirals for higher risk cases. This is the first time in the global pandemic that a growth advantage of variant has not translated into significant admissions 'for' COVID-19. However, the immune landscape in Europe and the US, is very different to that of New Zealand, Australia and Asia. For example, in contrast, the XBB variant did have a significant impact on hospitalisations in Singapore recently. In addition, the variant situation is very complex, making it difficult to predict if New Zealand will observe the same pattern.

Mortality

17. Deaths have been declining since peaking in the last week of July 2022, though the decline has slowed in the past few weeks.

The last COVID-19 PHRA was held two weeks ago

18. Following the previous COVID-19 PHRA on 7 November 2022, the Director of Public Health recommended:

Table 1: Director of Public Health recommendations following PHRA on 7 November

s9(2)(f)(iv)	
Face masks	**Retain** the current face mask mandate in health service settings. s9(2)(f)(iv)
Case isolation	**Retain** the 7-day case isolation requirement, with further review in two weeks' time noting further data will be available.
Public health messaging	**Encourage** summer messaging that supports public health behaviours and adherence to measures over the holiday period.

19. The purpose of the PHRA on 22 November was to build on, and provide further clarification of, the recommendations developed following the PHRA on 7 November 2022 with the knowledge of more recent data.

Our current strategy and approach to managing COVID-19

20. The current approach to managing COVID-19 by being 'prepared, protective, resilient, and stable' is based on using a suite of measures to address general and specific risks. It is important that measures are not viewed in isolation, but rather that, when taken as a whole, they help to minimise the harm of COVID-19 to individuals, whānau, communities, businesses and the wider health system.[2]

21. Our approach for managing COVID-19 is also guided by the Strategic Framework for COVID-19 Variants of Concern that uses five scenarios, based on the characteristics of the dominant variant(s).3 The current scenario is one with mixed variants where multiple variants persist throughout the wave. While the degree of immune evasiveness varies among circulating variants the overall picture is one of relatively low severity and high transmission.

Legal mechanism to support the COVID-19 response

22. Authorisation under section 8(c) of the COVID-19 Public Health Response Act 2020 provides the legal basis for case isolation requirements and face mask requirements in health service premises. The current COVID-19 Public Health Response (Authorisation of COVID-19 Orders) Notice 2022 (the Notice) that provides this authorisation is due to expire on 20 January 2023.

23. Any new or modified requirement, as well as an extension to the duration of the Notice, will require an updated authorisation notice. Authorisation requires the Prime Minister to be satisfied that there is a risk of an outbreak or the spread of COVID-19. Manatū Hauora will provide this advice to the Prime Minister, which will be coordinated with the DPMC-led Cabinet paper on summer settings to be considered by Cabinet's Social Wellbeing Committee on 7 December 2022, and then Cabinet on 12 December 2022.

Detailed recommendations and rationale

24. The purpose of COVID-19 PHRAs are to assess the current and medium-term COVID-19 risk and to consider whether there needs to be any changes to the suite of public health measures to manage the risk. This can include recommendations to relax or escalate risk mitigation measures. In addition, the PHRA fulfils the legal requirement to keep mandatory measures (made via Orders) under regular review to ensure that they remain necessary and proportionate.

25. When combined, individual measures form a pragmatic approach to managing COVID-19. There are interdependencies between each, and we must remain aware of how they form a coherent package for the public to encourage and support the public health behaviours necessary to reduce transmission and limit the impact of COVID-19.

26. The principle of proportionality is a key consideration. This principle requires that the least restrictive measures are used and for no longer than is necessary to achieve the objective of preventing, minimising, or managing the COVID-19 public health risk. In assessing proportionality, it is important to account for both Tiriti o Waitangi and equity considerations as more restrictive measures may be required to achieve these objectives.

This section is withheld in full under section 9(2)(f)(iv) of the Act

s9(2)(f)(iv)

Face masks

[redacted]	s9(2)(f)(iv) [redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Public health rationale	6. Evidence that wearing a face mask decreases the rate of COVID-19 community transmission (and other airborne respiratory viruses) is substantial (HR20221311 outlined the evidence base of their use and mandates). 7. Face mask mandates are an effective way to limit community transmission. Overseas evidence suggests it increases adherence[3], are associated with reductions in COVID-19 case and mortality growth rates[4 5 6 7], and the that the timing of when face mask mandates are applied matters - early application is associated with a reduction in cases and mortality rates.[8] 8. The effectiveness of face mask mandates as a public health intervention depends on several factors. This includes the current level of community transmission, the nature of the settings in which masking is required, cultural and geographical norms around masking, correct use, social licence and compliance and the extent to which improvements to ventilation/filtration have been enacted as systemic primary prevention. 9. Face mask mandates lean against inequity, to ensure that people who are at higher risk can access basic services without avoidable additional risk. A conservative estimate is that one in every six New Zealanders is at higher risk of severe illness if they contract COVID-19.[9] Mandates have two benefits for those people: it means that they will be less likely to be infected and be more likely to feel able to continue to safely participate in basic activities of life, eg. accessing healthcare, catching the bus, or visiting people over the summer.

Health service settings

10. Health service settings have a series of characteristics that elevate the risk of transmission and/or the risk of severe disease. These settings typically:

    a. may be more likely than other settings to have people present with undifferentiated viral illness, either because they are seeking help for symptoms or because they have a co-existing medical emergency

    b. are more likely to have vulnerable people present, either due to advanced age, underlying conditions, or to being unwell at the time - facility-level face mask requirements lean against inequity, to ensure that people who are at higher risk can access health services without avoidable additional risk

    c. have variable ability to improve crowding, indoor ventilation and/or air filtration[10]

    d. hospital-acquired COVID-19 infections are more likely to have poorer outcomes than community-acquired infections11 - feedback from two districts has noted possible links between visitors and hospital-acquired cases of COVID-19

    e. people often do not have a choice in whether they access a health service.

11. While adherence to face mask requirements may be waning or patchy in some health service settings, adherence could drop further if the mandate was removed, as evidenced by the decreased use on public transport since the mandate was dropped in mid-September (but has remained recommended by Manatū Hauora).

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

Page 15 is withheld in full under secton 9(2)(f)(iv) of the Act

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

Case isolation

Current requirement	Mandatory 7-day self-isolation of COVID-19 cases.
PHRA Committee recommendation	**Retain** the 7-day case isolation requirement.
Director of Public Health comment	1. The Committee considered evidence from a recent survey that young people, Māori, Pacific and Asian people are more likely to experience work related barriers to isolation. Māori and Pacific are also more likely to be unable to isolate due to the need to take care of others. The Committee was unable, however, to establish whether the reported barriers are resulting in adverse impacts such as loss of income or job loss. 2. There is therefore a potential that unnecessarily requiring isolation at day 6 and 7 when a case is no longer infectious may contribute to inequity associated with isolation. A majority of committee members however took the view that the introduction of a test to release policy that could reduce the adverse impacts of isolation was more likely to increase inequity overall because of the risk that a test to release strategy would result in a general trend to ceasing isolation after 5 days without testing. In the absence of definitive evidence either way I concur with the Committee noting that further planned analysis of survey data may inform a review of this recommendation.
Public health rationale	3. Based on the current outbreak status and epidemiological context, the requirement should remain with further review at the next PHRA. 4. By then, further evidence to inform the PHRA is likely to be available, including more trend data and behavioural insights regarding adherence to mandates and other public health measures. 5. The rationale for continuing to require self-isolation is as follows: a. Isolation of cases remains the cornerstone of New Zealand's public health response to COVID-19. This measure significantly limits transmission of COVID-19 as it helps to break the chain of transmission by reducing the proportion of infectious people having contact with and infecting others in the community, many of whom may be at high risk of poor outcomes. b. Without mandated case isolation, it is highly likely adherence to guidance would be lower, resulting in more infectious cases seeding community transmission and increasing overall case rates. c. Overseas evidence suggests that a legal requirement to isolate results in significantly greater adherence than a recommendation to isolate. Experience when other mandates (eg masks) have been removed in New Zealand reinforces the fact that adherence to guidance is typically much

	lower than to mandates. However, given cases may be unwell from the symptoms of COVID-19, there may be a higher adherence to self-isolation guidance than for other measures. d. While there has been a reduction in isolation requirements over the course of the outbreak, we have reached what is probably the minimum threshold for self-isolation of cases to remain an effective intervention. A mandatory requirement for 5-day isolation would not be an effective intervention, as the majority of people would still be infectious to some degree on release at 5 days. e. Other infection control tools, such as requiring face masks or physical distancing are significantly less effective than isolation. We have been able to recommend removing or reducing some of those other tools in part because case isolation has remained in place. However, there is no combination of other mechanisms that would come close to producing the public health benefit that required case self-isolation does. 6. Advice from the 7 November 2022 PHRA continues to be relevant and has been updated in Appendix 4 to ensure that this measure continues to be reviewed and monitored. This ensures that it remains a proportionate and effective at limiting the impact of COVID-19.
Other comments	7. The recommended changes to essential permitted movements (as outlined earlier), will reduce some potential burden of isolation and address potential equity issues.

Equity and Te Tiriti o Waitangi

Impact of COVID-19 on vulnerable populations

27. Pacific peoples and Māori continue to have the highest hospitalisation rate compared to other ethnicities, after standardising by age (refer Appendix One). In the week ending 23 October 2022, age-standardised rates for hospitalisation for COVID-19 decreased for all ethnicities except Pacific peoples. COVID-19 attributed mortality rates are also higher among Pasifika (2.4x) and Māori (1.9x), compared to European and other ethnicities.

28. The most deprived populations continue to have the highest rates of hospitalisation, and have twice the risk of hospitalisation, compared with those who are least deprived.

29. Disabled people who receive the Disability Support Services Payment also have a hospitalisation risk that is approximately four times higher than the general population. Further, rates of COVID-19 attributed mortality are approximately 1.5 times higher among this group compared to the rest of the population.

30. Modelling predicts that the mid-December 2022 peak will see 1800 daily new cases among Māori and 800-900 daily new cases among Pacific Peoples. It also indicates that during the peak there may be 30 Māori and 15 Pacific Peoples hospital admissions per day.

31. Committee members emphasised that any reductions of public health measures will increase prevalence of Long COVID, and that this increased prevalence will disproportionately impact Māori, Pacific Peoples and disabled people. Further, reductions of public health measures pose a risk to those who already have Long COVID, as they are more susceptible to reinfection, and reinfection can worsen their Long COVID symptoms.

Addressing equity concerns

32. Whaikaha representatives on the committee note that the reduction in measures over time has caused anxiety amongst vulnerable communities. For example, amongst disabled people, many are opting for ongoing isolation or limiting interactions with others in their community due to the perceived or actual risk. There is also an ongoing concern that the public may not take the risk of COVID-19 seriously, and adhere to public health measures, putting vulnerable populations further at risk.

33. In a Manatū Hauora survey conducted between 29 September and 9 October 2022, Māori health providers indicated that targeted Māori holistic immunisation programs and addressing the impacts of Long COVID were the areas of highest importance for them and their communities.

34. There is a strong preference to build 'borders' around vulnerable populations, through either differentiated public health responses or the retention of current requirements.

Equity considerations in these recommendations

35. With a new wave of cases expected to peak in the latter part of December, it is important that public health measures improve health equity and uphold Te Tiriti o Waitangi principles by protecting groups who are most vulnerable to COVID-19.

36. There was support among Committee members for retaining and increasing existing mandated measures to protect vulnerable communities. The removal of other measures in recent months were considered to have already put these communities at greater risk.

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

39. Stakeholders from the disability community have expressed concern around the lack of mask wearing by drivers in taxis and ride share vehicles. Many disabled people rely on taxis and ride shares for essential travel. Clinicians have echoed this concern and added that ventilation and mask guidance should be provided to taxi companies and ride share operators.

40. There was support among most Committee members to retain the 7-day isolation requirement. Committee members expressed concern that changing to 5-day test to release might confuse people, and would place some vulnerable people under pressure from their employers to return to work after 5 days of isolation, regardless of whether a negative test has been taken. They also said that 7-day isolation reduces the risk of

infectious cases leaving isolation, and of cases getting Long COVID as it encourages cases recover fully before returning to work and activities such as exercise.

41. If the COVID-19 situation significantly changes, enforceable or mandatory measures may be re-introduced to protect our vulnerable populations. This would be an effective and proportionate response to a worsening risk profile.

s9(2)(h)

[redacted]

[redacted]

s9(2)(h) [redacted]

[redacted]

Next steps

49. Pending your agreement, we will share this memo with DPMC, the Minister for COVID-19 Response's Office, and the Parliamentary Counsel Office.

50. On 28 November you will provide advice to the Minister for COVID-19 that draws on this memo and any additional information or advice you wish to include.

51. That PHRA and your subsequent advice to Minister for COVID-19 Response will then inform a DPMC-led Cabinet paper on that topic to be considered by Cabinet's Social Wellbeing Committee on 7 December 2022, and then Cabinet on 12 December 2022.

Recommendations

It is recommended that you:

1	**Note**	that on 22 November 2022, a public health risk assessment (PHRA) considered the current and medium term COVID-19 risk, reviewed existing mandated measures whether any changes were needed to current settings.	**Noted**
2	**Note**	overall, the key measures of infection used to monitor the COVID-19 epidemic show mixed trends in the past week - case rates have increased, whilst wastewater quantification, hospital admissions, and mortality have started to stabilise.	**Noted**
3	**Note**	that it is possible that over the next few weeks, cases, hospitalisations and mortality could increase; however, the magnitude, timing, and duration of the peak and new baseline trends of cases, hospitalisations and mortality is currently uncertain.	**Noted**
4	**Note**	that possible causes for this increase are waning immunity, new variants, or changes in behaviour (or a combination of these factors).	**Noted**

5	**Note**	s9(2)(f)(iv)	
6	**Note**	that the PHRA considered the settings relating to the remaining mandatory requirements for: i. s9(2)(f)(iv) ii. mandatory mask use iii. mandatory 7-day self-isolation	**Noted**

7	**Note**	that as the Director of Public Health I recommend the following to: i. s9(2)(f)(iv) [redacted] iii. **Clarify** in the Self-isolation Order that the exemptions permitted in the Mask Order from the requirement to wear a face mask do not apply to cases. iv. **Retain** the current face mask mandate for health service settings. v. s9(2)(f)(iv) [redacted] vi. **Retain** the 7-day case isolation requirement.	**Noted**
8	**Agree**	s9(2)(f)(iv) [redacted]	

		iii. **Clarify** in the Self-isolation Order that the exemptions permitted in the Mask Order from the requirement to wear a face mask do not apply to cases.	**Yes**
		iv. **Retain** the current face mask mandate for health service settings.	**Yes**
		v. s9(2)(f)(iv) [redacted]	[redacted]
		vi. **Retain** the 7-day case isolation requirement.	**Yes**
9	**Note**	that on 28 November you will provide advice to the Minister for COVID-19 Response based on this memo.	**Noted**
10	**Agree**	to forward this memo to the Department of the Prime Minister and Cabinet (DPMC), the Minister for COVID-19 Response's Office, and the Parliamentary Counsel Office for their information.	**Yes**
11	**Note**	that DPMC is preparing a paper for the Minister for COVID-19 Response, to confirm the suite of mandated and other measures in place over the summer period to be considered by Cabinet's Social Wellbeing Committee on 7 December 2022 and Cabinet on 12 December 2022.	**Noted**

Signature Date: 25 November 2022
Dr Nicholas Jones
Director of Public Health
Public Health Agency

Signature Date: 28 November 2022
Dr Diana Sarfati
Director-General of Health
Manatū Hauora

Appendix 1: Trends and Insights Report (18 November 2022)

Appendix 2: Summary of modelling

1. COVID-19 Modelling Aotearoa (CMA) used a stochastic simulation model to calculate average population-level case isolation outcomes for a range of metrics.

2. Moving from the current 7 days isolation (no TTR) to 5 days isolation (plus negative TTR) increases the time cases are infectious in the community but reduces the amount of excess isolation.

3. Switching from the status quo of 7 days isolation to 5 days isolation (max 7 days with one negative TTR) isolation results in an increase in the average number of hours infectious post-release per confirmed case: from 8.9 to 12.4 hours (+39%).

4. This increased risk is accompanied by a decrease in the average number of hours spent in isolation after the infectious period ends (excess isolation): 83.2 hours drops to 50.9 hours (-39%).

5. As contrast, a pessimistic scenario accounting for no TTR and low compliance in switching from status quo to 5 days with no TTR). This resulted in an increase in the average hours infectious post-release per confirmed case: from 8.9 to 19.3 hours (+56%) compared to status quo.

6. Preliminary modelling analysis indicated that the recent changes to contact quarantine rules on the 12 of September increased overall transmission between 8.5% to 15%.

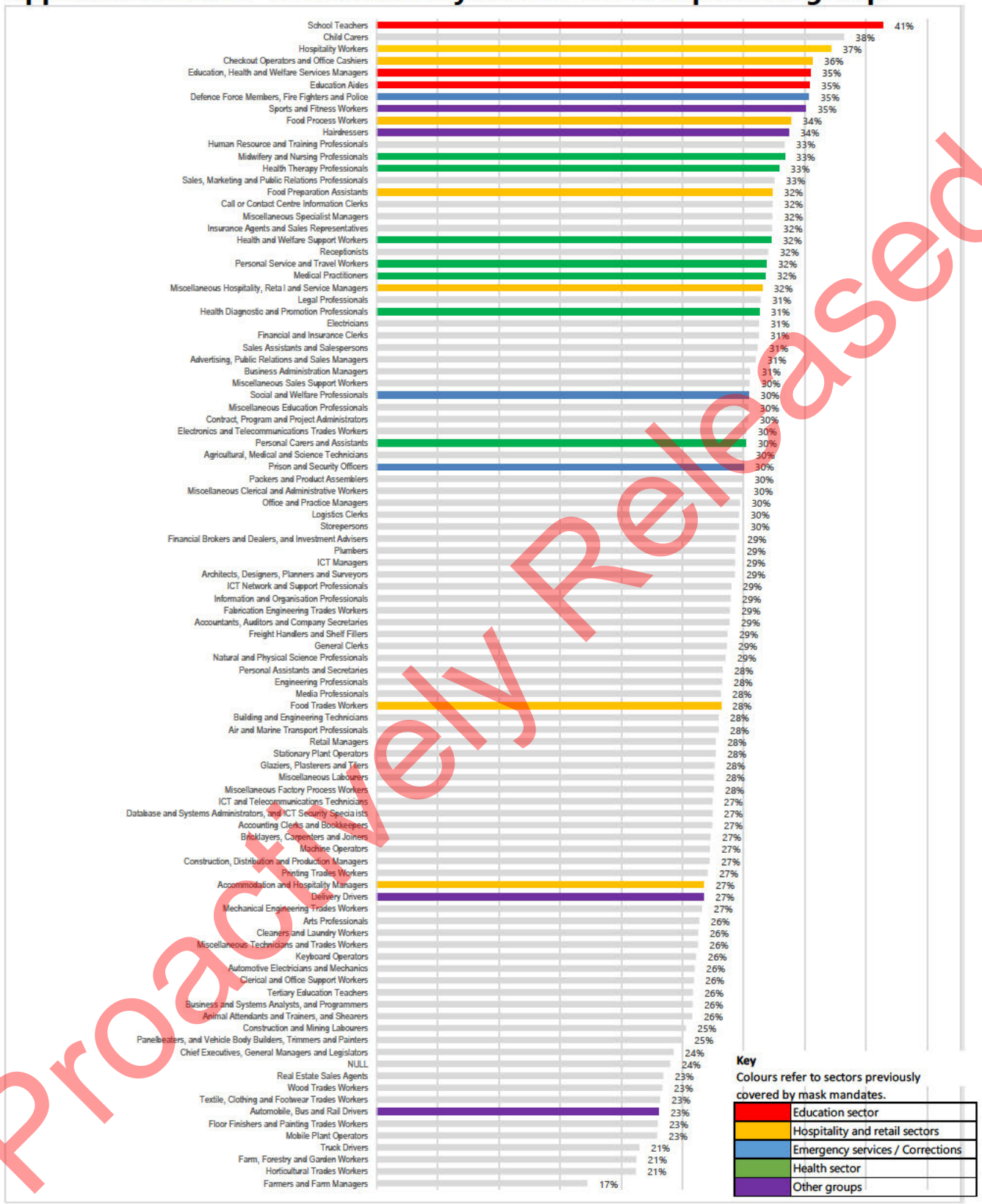
	7 days, no TTR	TTR; min 5, max 7		5 days, no TTR
RAT sensitivity modelled	-	75% RAT sensitivity	95% RAT sensitivity	-
Average hours infectious post-release	8.9 hrs [5.1, 13.5]	12.4 hrs [7.9, 18.1]	10.0 hrs [5.8, 15.2]	19.3 hrs [12.4, 27.1]
Average hours excess isolation	83.2 hrs [72.8, 94.3]	50.9 hrs [44.0, 57.9]	53.0 hrs [45.8, 60.5]	45.2 hrs [37.9, 53.4]
Average isolation duration	7.5 days	6.1 days [6.0, 6.2]	6.2 days [6.1, 6.3]	5.5 days
Percent of cases infectious at release	14.6% [9.7%, 20.1%]	20.8% [15.4%, 26.9%]	17.6% [12.1%, 23.7%]	29.7% [22.4%, 37.2%]

7. The 75% sensitivity results are likely to be a pessimistic estimate of test sensitivity, as literature which compares viral culture to RAT results finds test sensitivities of 90-95%.

8. These results could be interpreted as already incorporating some level of poor RAT technique and reduced compliance in testing. The higher sensitivity estimate for RATs (95%), reflects a high compliance situation. In this case the effectiveness of the TTR policy increases, in terms of reductions in both hours infectious after release and proportion released while still infectious. The higher RAT sensitivity estimates result in very little increase in the overall average isolation time and excess isolation.

Appendix 3 is withheld in full under section 9(2)(f)(iv) of the Act

Appendix 4: COVID-19 case rates by ANZSCO L3 occupational group[38]



Endnotes

[1] The mandate requires people to wear a mask when they are on the premises of a health service unless they are a patient or a worker of the health service, or they are receiving residential care at the premises, or the premises provides psychotherapy, counselling, mental health, or addiction services. Health service is defined very broadly – see the website for further details: https://covid19.govt.nz/prepare-and-stay-safe/protect-yourself-and-others-from-covid-19/face-masks/wearing-a-face-mask/

[2] The mandate requires people to wear a mask when they are on the premises of a health service unless they are a patient or a worker of the health service, or they are receiving residential care at the premises, or the premises provides psychotherapy, counselling, mental health, or addiction services. Health service is defined very broadly – see the website for further details: https://covid19.govt.nz/prepare-and-stay-safe/protect-yourself-and-others-from-covid-19/face-masks/wearing-a-face-mask/

[3] Adjodah D, Dinakar K, Chinazzi M, Fraiberger SP, Pentland A, Bates S, et al. (2021) Association between COVID-19 outcomes and mask mandates, adherence, and attitudes. PLoS ONE 16(6): e0252315. https://doi.org/10.1371/journal.pone.0252315

[4] Guy GP Jr., Lee FC, Sunshine G, et al. Association of State-Issued Mask Mandates and Allowing On-Premises Restaurant Dining with County-Level COVID-19 Case and Death Growth Rates — United States, March 1–December 31, 2020. MMWR Morb Mortal Wkly Rep 2021;70:350–354.

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[8] Wong, Angus K.; Balzer, Laura B.. State-Level Masking Mandates and COVID-19 Outcomes in the United States: A Demonstration of the Causal Roadmap. Epidemiology: March 2022 - Volume 33 - Issue 2 - p 228-236 doi: 10.1097/EDE.0000000000001453

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

[10] Many health service settings do not have good design or engineering. Therefore, the value of face masks to protect those more vulnerable increases when there is frequent introduction of infection into those environments. This is true of community healthcare settings, but also is an issue in many hospitals as older wards are mostly multibed rooms (eg. 4-6), have shared bathrooms and no doors on rooms, making it hard to isolate and improve air filtration.

[11] In Victoria, Australia, 7.6% of hospital-acquired infections resulted in death, compared to 0.14% of reported cases in the general population in the same period. This shows that infections in hospital settings are associated with significantly (over 50-fold) higher mortality. Victoria Department of Health. 2022. Chief Health Officer Advice to Premier, 29 August 2022.

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

[27] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19latestinsights/infections

[28] Cutler DM. The Costs of Long COVID. *JAMA Health Forum.* 2022;3(5):e221809. doi:10.1001/jamahealthforum.2022.1809

[29] For example, a November 2022 report from the Office for National Statistics in the UK estimated that 2.1 million people living in private households (3.3% of the population) were experiencing self-reported long COVID (symptoms continuing for more than four weeks after the first suspected COVID-19 infection that were not explained by something else) as at 1 October 2022. See https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19latestinsights/infections

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[33] https://pharmac.govt.nz/news-and-resources/covid19/access-criteria-for-covid-19-medicines/covid-antivirals/

[34] https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-health-advice-public/about-covid-19/getting-reinfected-covid-19

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

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

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

SWC-22-MIN-0240

Cabinet Social Wellbeing Committee

Minute of Decision

COVID-19 Measures for Summer

Portfolio **COVID-19 Response**

On 7 December 2022, the Cabinet Social Wellbeing Committee:

Background

1 **noted** that since October 2022, New Zealand has had the following COVID-19 requirements in place:

1.1 seven-day mandatory self-isolation for cases; and

1.2 government-mandated mask requirements for visitors to certain healthcare services, including pharmacies but not counselling services;

2 **noted** that there is an authorisation under 8(c) of the COVID-19 Public Health Response Act 2020 (the Act) in place to allow for the making of COVID-19 orders for self-isolation of cases and masks for visitors to health care settings until 20 January 2023, and that the Prime Minister will receive advice in mid-December 2022 on extending the expiry date beyond 20 January 2023;

Review of case isolation requirements

3 **agreed** that self-isolation of cases retain the status quo of seven-day mandatory self-isolation, as recommended by the Director-General of Health;

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

Review of government mandated mask requirements

5 **agreed** to retain government-mandated mask requirements for visitors to healthcare services;

Next steps

6 **noted** that, to give effect to the above decisions, the Minister for COVID-19 Response will, if required, amend the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022;

7 **noted** that the above decisions will be announced during the week of 12 December 2022;

8 **noted** that COVID-19 response settings will be reviewed again in early February 2023.

Rachel Clarke
Committee Secretary

Present:
Rt Hon Jacinda Ardern
Hon Grant Robertson
Hon Kelvin Davis
Hon Chris Hipkins
Hon Carmel Sepuloni (Chair)
Hon Andrew Little
Hon Poto Williams
Hon Damien O'Connor
Hon Peeni Henare
Hon Willie Jackson
Hon Jan Tinetti
Hon Kiri Allan
Hon Dr David Clark
Hon Dr Ayesha Verrall
Hon Priyanca Radhakrishnan
Hon Meka Whaitiri

Officials present from:
Office of the Prime Minister
Office of the Chair
Officials Committee for SWC

Cabinet

Minute of Decision

Report of the Cabinet Social Wellbeing Committee: Period Ended 9 December 2022

On 12 December 2022, Cabinet made the following decisions on the work of the Cabinet Social Wellbeing Committee for the period ended 9 December 2022:

[redacted]

[redacted]

SWC-22-MIN-0240 **COVID-19 Measures for Summer** CONFIRMED
Portfolio: COVID-19 Response

Rachel Hayward
Secretary of the Cabinet