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

Proactive Release

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

New Zealand's future quarantine and isolation capability

The following document has been included in this release:

Title of Letter: Strategic COVID-19 Public Health Advisory Group: New Zealand's future quarantine and isolation capability

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Key to redaction codes:

- Section 9(2)(g)(i), to maintain the effective conduct of public affairs through the free and frank expression of opinion.

Strategic COVID-19 Public Health Advisory Group

18 November 2022

Hon Dr Ayesha Verrall
Minister for COVID-19 Response
Parliament Buildings
Wellington

Dear Minister

New Zealand's future quarantine and isolation capability

Thank you for meeting with the Strategic COVID-19 Public Health Advisory Group on 2 November 2022 and for providing us with written commissioning on 4 November 2022. We welcome your invitation to provide feedback on the business case, and associated Cabinet paper, on New Zealand's future quarantine and isolation capability.

Scope of this advice

1. We note your commission as follows:

    a. *I seek the Group's advice on the New Zealand's future quarantine and isolation capability Cabinet paper and Programme Business Case.*
    b. *I invite the Group to comment on the assumptions made in the paper on the success of New Zealand's hotel based Managed Isolation and Quarantine system.*
    c. *I also seek the Group's advice on the three proposed options in the paper.*

2. In response, we have focused on the strategic case and the three proposed options, including whether the business case adequately addresses the nature of infectious disease threats that we face and how those threats, and the associated future risks, are evaluated. We have focussed on the health, and not commented on the commercial, financial or management, aspects of the business case.

3. We acknowledge the Department of Prime Minister and Cabinet secretariat who supported this work and the production of this report.

It is important to be prepared for future infectious disease threats

4. We want to use this opportunity to stress the importance of preparedness for the next significant infectious disease threat. This must include building capability (in terms of infrastructure and workforce) to quickly stand up a coordinated, flexible, nimble response that is joined up across key aspects, including but not limited to quarantine and isolation capabilities.

5. We also emphasise the important role that primary care and health services connected to local communities, particularly Māori and Pacific providers, have played in supporting the COVID-19 response. This should not be overlooked in future planning.

6. Acknowledging the recent investment and work underway, we also emphasise the importance of continued investment in the field of infectious disease. We support strengthening collaboration, integration, and clear leadership in this space to support New Zealand's readiness for future infectious disease threats.

7. The narrative on the nature of future infectious disease threats should be clarified in the Cabinet paper. We agree that in future the frequency of disease threats is likely to increase and may rapidly spread to and throughout New Zealand. While the timing of some infectious disease risks is unpredictable, we have a good understanding of the kind of likely diseases and their parameters that would require quarantine and isolation capability, such as a respiratory (or gastroenterological) disease threat. This should inform decision-making.

8. The Cabinet paper could further benefit from consideration of the difference between isolation and quarantine. That is, grouping ('cohorting') patients for isolation in a single infectious disease outbreak is possible when they have the same disease (which enables more effective use of space). We acknowledge the requirements for quarantine are different because infection is suspected but not confirmed. This could be addressed more explicitly in the proposals and has implications for understanding the role of the health sector and the use of a range of different facilities in New Zealand's future quarantine and isolation capability – a key gap which we address further in our discussion below.

9. We also stress that New Zealand's future quarantine and isolation capabilities have a role not only concerning future human infectious diseases in an epidemic or pandemic setting, but also for localised and/or domestic outbreaks (e.g., as seen with measles). Regardless of the severity of future disease threats, having a quarantine and isolation system will be a critical component of New Zealand's

response to future infectious disease threats. We acknowledge that the hotel-based system, while not perfect, was an effective element in terms of infectious disease prevention and critical to the success of New Zealand's COVID-19 response.

10. Given the uncertainty of new infectious disease threats, we also cannot overstate the importance of investment in infection prevention across the health sector itself to protect the health, wellbeing, and safety of the isolation/quarantine and health workforce. Making these facilities safe employment environments is another important aspect of New Zealand's future pandemic preparedness.

s 9(2)(g)(i)

s 9(2)(g)(i)

16. We strongly support the approach to incorporate lessons from the COVID-19 Care in the Community support into New Zealand future quarantine and isolation capabilities. This will help ensure flexibility to respond to varied local community needs, including to support people who cannot safely isolate or quarantine in their own homes. This should include considering whānau needs, optimising surveillance capacity nationally, and improving capability to support those with mental health issues, drug/alcohol addiction, social challenges, or insecure and overcrowded housing.

17. Further thought also needs to be given to how to operationalise the system so that it works rapidly and effectively, including by considering location and size of the facilities. It is important to have some facilities outside of the main centres, noting that smaller facilities could be effective in an outbreak response.

18. We also think several aspects of option three require further consideration.

    a. While the business case references other countries/jurisdictions that already had purpose-designed facilities prior to the COVID-19 pandemic, it lacks discussion on whether these facilities were useful for managing COVID-19 or, more important, whether other jurisdictions similar to New Zealand are exploring investment in purpose-designed facilities to manage future pandemics (and if so, their justification for doing so).

[2] For example, considering improved ventilation and physical distancing needs, particularly for infectious diseases with a high risk of aerosol transmission.

s 9(2)(g)(i)

19. A final aspect we highlight for further consideration in developing the detail of the proposal for New Zealand's future quarantine and isolation capability is the need for an ongoing evaluation process to be in place to continuously review our systems based on lessons learned.

20. Overall, we support and stress again the importance of increased investment in infectious disease preparedness for the future. This will be a critical aspect of working towards achieving our health equity goals. We consider that an approach that sits on the continuum between options two and three, would prepare New Zealand well for a future infectious disease threat.

We would be happy to discuss any of our feedback with you.

Yours sincerely

Nikki Turner (Chair)
Maia Brewerton
David Murdoch
Ella Iosua
Matire Harwood
Patricia Priest

[3] We note the reference to the Australian model which assumes a four-to-eight weeks timeframe to stand up quarantine and isolation using their purpose-designed facility.