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Office of the Minister for COVID-19 response

Office of the Attorney-General

Office of the Associate Minister of Health

Cabinet

Maximising COVID-19 vaccine uptake in tier one

Proposal

1 This paper outlines:

1.1 the Government's approach to maximising the uptake of COVID-19 vaccines in the border and Managed Isolation and Quarantine (MIQ) workforces, who will be offered the vaccines first when supplies are limited (Tier 1 of the Sequencing Framework)

1.2 additional levers that may further increase vaccine uptake.

Relation to government priorities

2 COVID-19 vaccines are an important part of the Government's Elimination strategy. They will protect an individual from more serious illness if they contract COVID-19, and may prevent people from becoming infected, and/or reduce COVID-19 transmission.

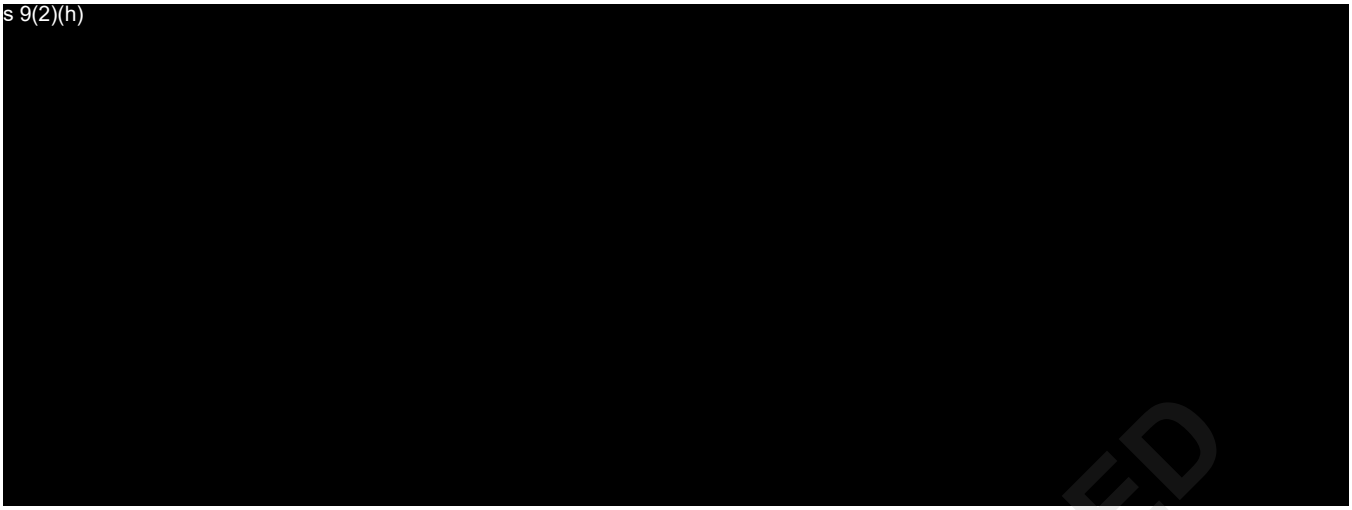
3 High COVID-19 vaccine uptake, in combination with other public health measures, will support the Elimination Strategy and New Zealand's ongoing economic, social and cultural recovery.

Executive Summary

4 High uptake of the COVID-19 vaccines, particularly within the border and MIQ workforce is vital. Providing these workers and their household contacts with access to a COVID-19 vaccine as early as possible is another way we can help keep them safe while they continue their important work to protect New Zealand.

5 Given the risk that the border and MIQ workforce faces, we consider it likely that many will be motivated to receive COVID-19 vaccines. This will be consistent with the expectation that, in order to work in this high-risk workforce, these workers should be vaccinated.

6 The Government's strategic and multi-faceted approach will help to maximise vaccine uptake by border and MIQ workforces. This approach focuses on stakeholder engagement, communications and service design to reduce barriers to immunisation and get as many people vaccinated as possible, including options to address potential financial barriers to vaccine uptake.



Background

10 The rollout of COVID-19 vaccines in New Zealand is progressing quickly and more transmissible variants of the virus are circulating internationally. We are monitoring other countries' approaches to increasing COVID-19 vaccine uptake to apply lessons in the New Zealand context.

11 Aotearoa/New Zealand has an Elimination Strategy for COVID-19. This represents our current approach to preventing and minimising harm associated with COVID-19. It aims to eliminate transmission chains in Aotearoa/New Zealand and prevent the emergence of new transmission chains from cases that arrive from outside the country. The Elimination Strategy draws on an array of public health measures and has a strong focus on the border, where the risk of infection and transmission is greatest.

COVID-19 vaccine supply will be constrained initially so rollout will be sequenced so that the right people get the right vaccine at the right time

12 The COVID-19 Immunisation Strategy aims to make the best use of any available vaccines. COVID-19 vaccine supply will be constrained initially so rollout needs to be sequenced so that the right people get the right vaccine at the right time. This means that while supplies are limited, those at greatest risk of infection will receive the vaccine first. Cabinet agreed in principle to a Sequencing Framework which identified who should receive COVID-19 vaccines first under three different transmission scenarios [CAB-21-MIN-0011].

We expect that vaccines will reduce transmission

13 While the extent to which the vaccines prevent COVID-19 transmission is not yet known, vaccination is expected to reduce transmission through reducing the severity of disease and therefore the risk of onward transmission.COVID-19 vaccination will support other public health measures to reduce the risk of these workforces contracting and spreading the virus. The use of Personal Protective Equipment (PPE), social distancing, and mandatory COVID-19 testing for border staff will still be needed to ensure that people continue to be safe.

14 The impact that COVID-19 vaccines have on transmission will need to be effectively communicated to the public. This will help build an understanding of the importance of everyone getting vaccinated. The Ministry of Health will continue to monitor emerging evidence on the effectiveness of vaccines at preventing transmission and build this into the overall communication messages.

15 6(b)(i) [redacted]

We have worked hard to protect our border and MIQ workforce

16 Having a safe and effective border is a key pillar of the Elimination Strategy. As such, the Government has taken steps to ensure border and MIQ workers are as safe and supported as possible while they carry out this important work, while also taking measures to ensure they do not inadvertently spread COVID-19 to the wider community. These measures include infection prevention controls, provision of PPE, high cleaning standards, limiting contact with people in MIQ facilities, compulsory and voluntary border testing.

17 In the current low/no community transmission scenario, the goal of the COVID-19 Immunisation Strategy is to prevent transmission of the virus first. This means protecting border and MIQ workers, and their household contacts first. This is because in a low/no community transmission scenario, the border is the primary source of COVID-19 infection in New Zealand. Nearly all COVID-19 cases in New Zealand have been linked back to people returning from overseas.

18 Providing our border and MIQ workforce with access to a COVID-19 vaccine as early as possible is another way the Government is working to keep them safe while they continue their important work to keep New Zealand safe.

19 There is a spectrum of options available to increase the uptake of the COVID-19 vaccine for Tier 1 workers, ranging from promoting vaccination and supporting workers to access the vaccine to firmer measures which place positive obligations on employers and/or employees to ensure that employees are vaccinated.

It is vital we have high vaccine uptake, particularly within the border and MIQ workforce.

20 There are discussions underway with border and MIQ agencies, employers and relevant unions on the best way to maximise uptake within their specific workforces. This includes exploration of specific workforce concerns or barriers to vaccination, and options to set clear expectations that their workforce, current and future, will be vaccinated.

21 Given the risk that the border and MIQ workforce faces, officials consider it likely that many will be motivated to receive COVID-19 vaccines. As in the general

population, there will be a small number of people who cannot be vaccinated or choose not to.

22 Therefore, the approach we take to maximise uptake of COVID-19 vaccines by the border and MIQ workforce must respond appropriately to educate and inform people by providing access to high quality information through a range of communication channels.

23 The Ministry of Health is also drawing on experience from past influenza and measles immunisation campaigns, evidence reviews and international experience of COVID-19.

24 Appropriate supports are also needed for those who are unable to take a vaccine. For example, some vaccine candidates have not yet completed trials in certain population groups (eg, children, people who are pregnant or lactating). Certain co-morbidities may also preclude vaccination, at least initially. There will therefore be some people, including in Tier 1, who cannot be vaccinated in the early stages of immunisation roll-out due to their unique circumstances. Having appropriate supports in place is also part of meeting the Crown's obligations under Te Tiriti o Waitangi and will help address barriers to access and ensure equity in uptake and access to vaccines.

Our approach is a strategic and multi-faceted one to increase vaccine uptake

25 As the barriers to vaccination uptake are multifaceted and the border and MIQ workforce is diverse, the Ministry of Health is working on a number of areas to maximise uptake of COVID-19 vaccines.

26 In particular, the Ministry of Health continues to design the COVID-19 Immunisation Strategy and Programme to proactively support the border and MIQ workforce to be vaccinated through:

26.1 stakeholder engagement

26.2 communications

26.3 service design.

27 More detail about this approach is outlined below. I consider this approach can address the key barriers to immunisation and strongly encourage people to get vaccinated. It is likely to influence the approximately 20 percent of people who, according to recent surveying, are hesitant to take a COVID-19 vaccine. These approaches are however unlikely to impact the approximately 10 percent of people that state they would refuse any vaccination. This is common to all vaccination programmes.

28 The wider rollout of the COVID-19 Immunisation Programme will be the most challenging in terms of maximising uptake of COVID-19 vaccines. It is important to take a measured and strategic approach now while not prematurely closing off options that may improve uptake in the future. If positioned carefully, our actions now will not preclude us from adopting additional measures in the future, as social pressure to vaccinate in the public interest grows. There is likely to be a strong community

expectation that all who can be vaccinated should be and there are a range of possible policy and legal choices to support this.

s 9(2)(f)(iv) [redacted]

Stakeholder engagement with the border and MIQ workforce to date provides a strong foundation

30 We have been working with border and MIQ agencies and employers on the delivery of COVID-19 immunisation to their workforces, including the service design and getting more information on the make-up of their workforces. This has provided a strong foundation from which to support and encourage their workforces to be vaccinated. Agencies and employers will be a key partner in the delivery, and we will continue to work with them to identify strategies to maximise uptake.

31 This is alongside other stakeholder engagement underway as part of the COVID-19 Immunisation Programme, for example to co-design targeted communications approaches with Māori.

32 There will also be some opportunities for individuals to interact and discuss any questions they have about immunisation directly with local experts, such as health practitioners.

Communications will seek to encourage uptake among Tier 1

33 As part of a broader public information campaign, we are working with a range of providers to design targeted approaches that will meet the information needs of New Zealand's diverse population, including border and MIQ workers.

34 We are engaging with border and MIQ operators, employers and unions to ensure that they have direct access to reliable information and support to address any key questions and concerns that might present barriers to the vaccination of border and MIQ workers and their household contacts.

35 We sent out key messages to workers in recent weeks on our approach to vaccination and why they should be vaccinated. We are continuing to build on this and expect to use a range of communications channels (including online, face-to-face and print collateral) to ensure the target workforces have access to high quality information that encourages uptake of the vaccine.

36 These targeted communications have a strong focus on encouraging the workforce to help protect themselves, their whānau and their community by getting vaccinated. This includes emphasising the safety and potential effectiveness of the Pfizer vaccine. We also need to be agile and will use ongoing research and sentiment monitoring to inform key messaging.

37 We know that the border and MIQ workforces do not all have the same communication needs. Therefore, in addition to the initial key messages, there will be targeted communications and education for some workers. For example, communications and education collateral will be produced in other languages (eg, Te Reo Māori and Pacific languages), and to address specific concerns about vaccination (eg, Māori have higher rates of vaccine hesitancy).

38 Border agencies are also planning to align their engagement with our phased approach to further educate and support uptake.

Our service design will make vaccination easy and accessible

39 To provide this immunisation service, district health boards (DHBs) will contract providers in their region.

40 While communications can support people to be willing to be vaccinated, our service design is intended to make it easy for them to take it up. For Tier 1, this means offering on-site vaccination at workplaces where possible, and partnering with employers to contact staff and schedule appointments in advance. Additionally, we are engaging with employers to encourage them to pay employees throughout the vaccination appointment, including the waiting period after. There will also be a strong emphasis on following up people to receive their second dose.

41 We are urgently working with employers and DHBs, and through privacy issues, to be able to capture information of household contacts for border workers and are exploring how employees can be encouraged to provide information about their household contacts. This would enable us to proactively invite household contacts to immunisation appointments.

The Ministry of Health and Border Agencies will continue to monitor uptake, emerging evidence on vaccines and the transmission context and will advise if a shift in approach is recommended

42 The Ministry of Health and Border Agencies will be monitoring daily COVID-19 vaccine uptake in border and MIQ workforces to enable us to see if our approach is working and whether additional levers should be considered.

43 Part of the role of the COVID-19 vaccine Technical Advisory Group is to continuously monitor emerging evidence about the vaccines, including emerging evidence on their effectiveness at preventing or reducing transmission of COVID-19. This evidence will be central to any decisions to change our approach to maximising vaccine uptake among border and MIQ workforces.

44 The Ministry of Health will ensure you receive regular reports on COVID-19 vaccination uptake and will provide you with regular opportunities to make decisions

about what (combination of) levers would best support the outcomes the COVID-19 Immunisation Programme. This reporting will also include a focus on equity and consistency with the Crown's Treaty of Waitangi obligations.

We have learnt from the staged approach to testing of the border and MIQ workforce

45 The staged approach to testing of the border and MIQ workforce suggests that good communications about how safe the vaccine is and how the vaccine will protect people and their whānau and their communities will likely be a part of any successful approach.

46 Before routine mandatory COVID-19 testing of border and MIQ workforces, some areas had high compliance and there was a general understanding of the need for testing to ensure health and safety. Following the introduction of the COVID-19 Public Health Response (Required Testing) Order 2020 (the Order), the vast majority of workforce who needed to be tested were being tested.

47 The Order required workers to get tested or get an exemption from a qualified health practitioner (in the course of carrying out work at a testing centre). A small amount of this workforce, according to a Ministry of Health survey, have since been redeployed to other duties if they cannot meet the testing requirements, however these opportunities are limited in some settings (eg, MIQ).

s 9(2)(f)(iv) [redacted]

48 s 9(2)(f)(iv), s 9(2)(h) [redacted]

49 s 9(2)(f)(iv), s 9(2)(h) [redacted]

50 s 9(2)(f)(iv) [redacted]

51 s 9(2)(f)(iv) [redacted]

Indicative options to address potential financial barriers to vaccination uptake

52 The more accessible vaccinations are the higher uptake will be. There may be a case for removing potential barriers or providing additional support to encourage the greatest possible vaccine uptake, given the importance of achieving our immunisation targets across the entire population. s 9(2)(f)(iv) [redacted]

53 The goal of the vaccination programme is to have uptake as high as possible in each tier of the roll-out. In addition to Tier 1a being the first line of defence at the border, the success of the overall vaccination campaign will be influenced by the progress of the Tier 1a (and 1b) rollout, so uptake should be maximised in these groups as far as possible. There may be value in signalling that the Government is committed to removing any potential barrier to vaccination.

54 Potential barriers to access could include opportunity cost-related barriers for workers and their household contacts, as well as work-related barriers.

Opportunity cost-related barriers to vaccination uptake

55 Opportunity-cost related barriers to vaccination uptake could include workers and their household contacts having to travel to be vaccinated and the cost of their time.

56 Providing an incentive such as a petrol voucher to cover the cost of travel, or a small token (eg, a sticker or a pen) to show people have been vaccinated, could provide further encouragement for people to be vaccinated.

57 s 9(2)(f)(iv) [redacted]

Work-related barriers to vaccination uptake

58 Generally, the more accessible vaccination is, the less likely work-related issues are to impede uptake. The COVID-19 Immunisation Programme and DHBs are working to provide workplace vaccination for Tier 1 wherever possible.

59 Work-related barriers to vaccination uptake could include workers not having paid leave to receive vaccination or having sick leave if they experience adverse reactions that require time off work.

There are options to remove additional work-related barriers to vaccination from encouraging employers to be supportive of vaccination through to the introduction of leave schemes

60 The table in Appendix Two was prepared by the Ministries of Business, Innovation and Employment; Social Development; and Health, and the Treasury.

61 s 9(2)(f)(iv) [redacted]

Officials do not think that a payment scheme will be required for Tier 1

62 It has been assumed that employers of border and MIQ workers are likely to provide paid time off to workers to receive vaccination, especially if vaccination is delivered at workplaces (reducing or eliminating travel time) and some workers are employed by government agencies.

63 The Border Executive Board is expected to confirm whether further financial support for people in Tier 1a is required in the coming days (eg, payment for the time it takes to be vaccinated). There are significant numbers of workers employed by private companies (eg, in MIQ facilities), meaning there could still be a benefit, in terms of encouraging uptake, from providing financial support to Tier 1a workers or their employers. This may particularly be the case where employers and workers are already facing tough conversations about whether vaccination is considered necessary for certain roles, and whether redeployment may be needed if people cannot or do not want to be vaccinated.

64 Financial support schemes or legislative change to create a right to paid time off are unlikely to be needed for Tier 1:

64.1 if the Government can support its direct and indirect workforces in Tier 1a (border and MIQ workforces); and

64.2 unless there are equity or other concerns about whether people in Tier 1a (eg, people who are indirectly or occasionally contracted to MIQ facilities) and Tier 1b (household contacts of border and MIQ workers) can access vaccination without further financial support.

65 s 9(2)(f)(iv) [redacted]

66 More work will be required to develop the options in Appendix Two if Ministers wish to explore them further. Understanding the particular barriers that different people may experience in relation to vaccination, and how these may manifest in the workplace is key. These barriers will largely depend on logistical details of the immunisation programme and roll-out. Our understanding at this stage is any scheme would be most useful targeted towards people without good in-work or after-hours vaccine access, and who are unable to take time off work to get the vaccine.

There are a range of leave support schemes you could consider to supplement the status quo for the wider programme

67 A number of current leave support schemes for COVID-19 are delivered by the Ministry of Social Development (eg, the Leave Support Scheme (LSS), which provides support for people who test positive for COVID-19 and are unable to work, or the Short Term Absence Payment (STAP), for people who need to stay home following a COVID-19 test). While it may be possible to modify existing schemes such as the LSS or STAP, a vaccine leave scheme targeted at people who cannot get paid leave from work and who cannot access vaccination outside work hours, is likely to be more complex than the existing support schemes because they are targeted or applied at an individual level rather than an employer level.

68 For example, it may be necessary to consider whether the leave support scheme should allow payments to be made either to workers or employers:

68.1 A scheme that made payments to employers would be more operationally feasible and could use the existing payment framework for Leave Support Scheme (LSS) and Short-term Absence Payment (STAP). A vaccine leave scheme that used the Ministry of Social Development delivery model would also need to be high-trust to be rolled-out in line with the immunisation strategy. This is to avoid jeopardising uptake through narrowly construed criteria that do not fully reflect and address barriers to vaccination. This means there would be limited verification of applications (ie, there would be no verification of whether someone had actually taken a vaccine). Integrity risks associated with a high-trust model, however, could be mitigated by targeting any scheme to types of recipients more likely to face work-related barriers to vaccination.

68.2 However, a scheme that would pay workers (rather than employers), would not be able to use the existing payment framework developed for the LSS, STAP and the Wage Subsidy Scheme (WSS) payments, which means that this option would be significantly more complex. Ministers considered, and discounted, a payment direct to employees for these schemes. Although technically possible, it would involve risks including difficulty assessing validity of applications (are people actually employed), implications with the welfare system and supports, and volume and administrative implications. Any payment to workers that involved confirming when someone has had a vaccination would need to involve an information sharing agreement between Ministry of Health, Inland Revenue and Ministry of Social Development. This is because standard upfront business verification checks done with Inland Revenue (under the LSS and STAP framework) would not be possible when payments are made directly to workers. Alternatively, another deliver agency other than the Ministry of Social Development could be considered.

69 Agencies also consider that there could be an argument for a leave support scheme that compensates for time off due to adverse reactions for up to a week, rather than time off to receive vaccinations. Severe adverse reactions are currently very rare, with current data suggesting severe adverse reactions is less than 1.1 percent.

Support schemes have timing and cost implications

70 The timing of when any of these options may need to be implemented by will also affect their level of granularity/complexity, and how well-targeted they are at potential barriers. For example, the trigger for existing payment support schemes is relatively straightforward (eg, having COVID-19 or needing to stay home following a COVID-19 test). By comparison, the trigger for any vaccine leave support scheme would either be an inability to access vaccination outside working hours, or an inability to use paid sick leave for adverse reactions. Creating a scheme that can differentiate between people who have met these conditions from those who have not, and potentially pay workers rather than employers, will take time. If a payment scheme needs to be implemented in the next month, it may end up having broader application than actually needed to achieve behaviour change (in terms of encouraging uptake).

71 In the time available, officials have been unable to calculate the potential cost and benefit of each option or obtain information about other countries' policies in this area. This further analysis would be completed as part of further work on any options.

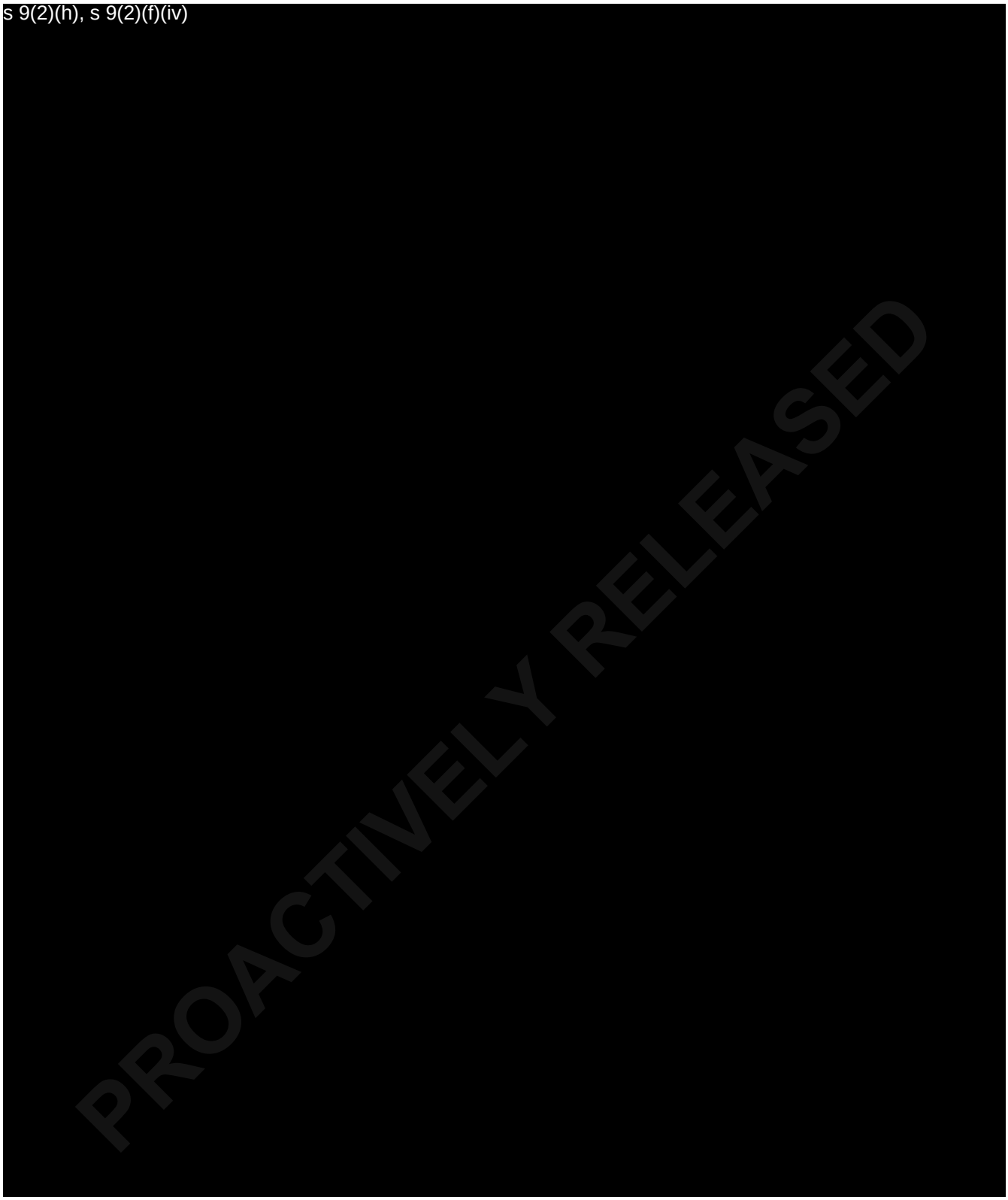
72 Very indicative costings of a financial support scheme (excluding administration costs) to support vaccination of people in Tier 1 are as follows:

Tier/number of people	*Payments to support time off to receive vaccination*	*Payments to support time off in case of adverse reactions*
Tier 1a (MIQ/border workers) 12,600 people	**$882,000 (excl. admin costs)** Assumptions: • Half of the people in this tier need support to access vaccination during work hours • Four hours needed to travel to and from a regional hub, and to receive vaccination • Two doses needed • Payment rate of $70 for four hours away from work (based on LSS and STAP rates)	**$48,650 (excl. admin costs)** Assumptions: • 1.1% of people receiving vaccination experience serious reactions of any type • Two doses needed • Of those, half need time off work as a result of serious reactions • Up to a week needed off work (if more than a week, an ACC claim can be made) • Payment rate of $350 (based on STAP rate)
Tier 1b (household contacts of MIQ/border workers) 40,000 people	**$1.4 million (excl. admin costs)** Assumptions: • Half of the people in this tier are working • Of those, half need support to access vaccination during work hours • Four hours needed to travel to and from a regional hub, and to receive vaccination • Two doses needed • Payment rate of $70 for four hours away from work (based on LSS and STAP rates)	**$77,000 (excl. admin costs)** Assumptions: • Half of the people in this tier are working • 1.1% of people receiving vaccination experience serious reactions of any type • Two doses needed • Of those, half need time off work as a result of serious reactions • Up to a week needed off work (if more than a week, an ACC claim can be made) • Payment rate of $350 (based on STAP rate)

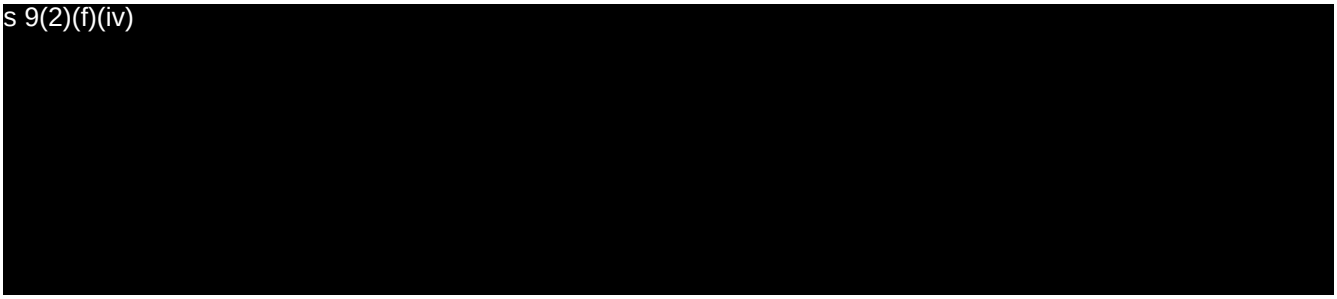
s 9(2)(h), s 9(2)(f)(iv)

[redacted]

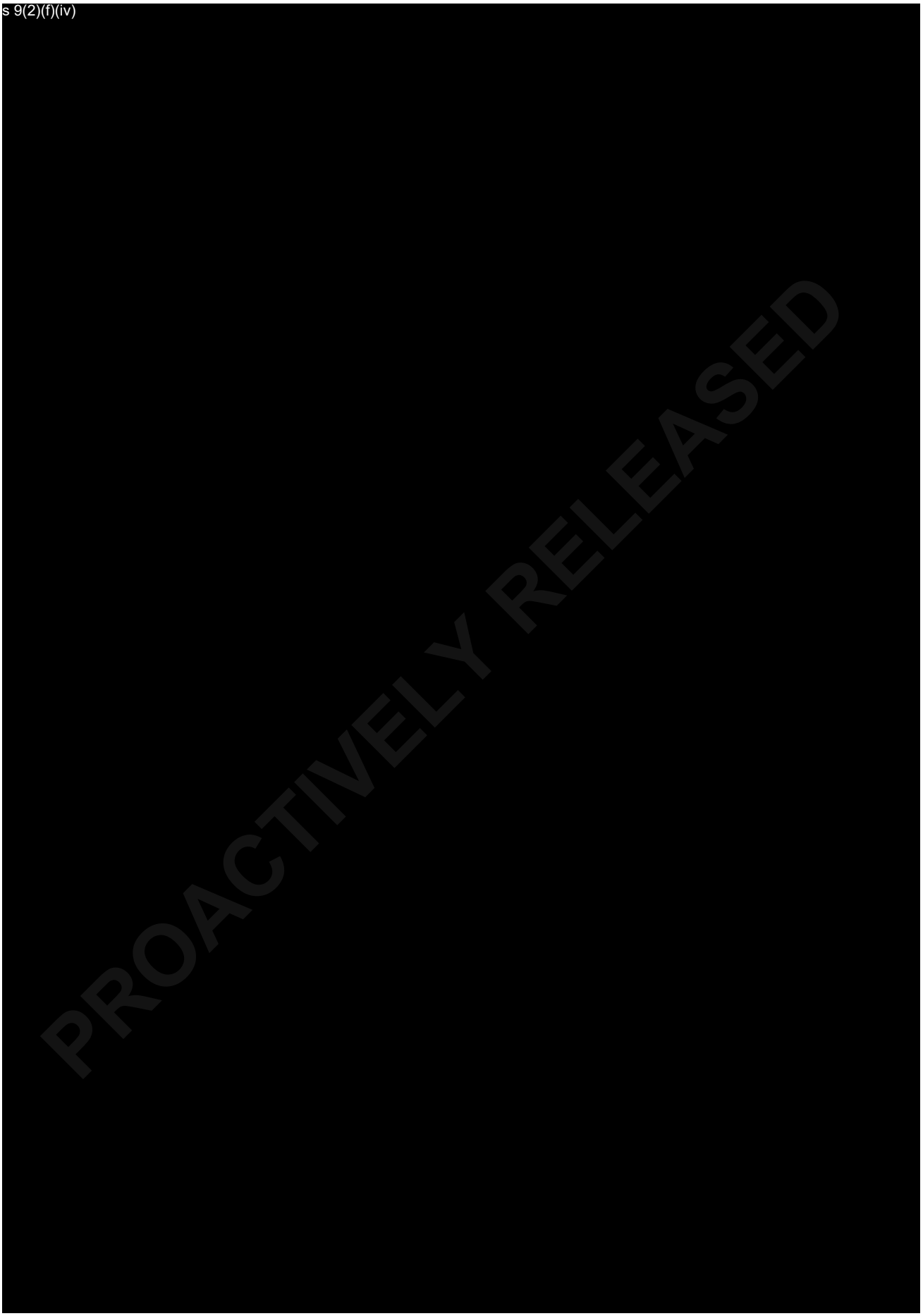
s 9(2)(h), s 9(2)(f)(iv)



s 9(2)(f)(iv)



s 9(2)(f)(iv)



s 9(2)(h), s 9(2)(f)(iv)

[redacted]

s 9(2)(f)(iv)

[redacted]

95 The Ministry of Health is ensuring that when border and MIQ staff give their consent for vaccination we will also get their consent to share their vaccination status with their employer. We will also make it clear in our Privacy Statements for the Covid-19 Immunisation Register. Other approaches to ensure we can share this information are being urgently investigated.

s 9(2)(f)(iv), s 9(2)(h)

[redacted]

s 9(2)(f)(iv), s 9(2)(h)

[redacted]

s 9(2)(h), s 9(2)(f)(iv)

[redacted]

s 9(2)(h), s 9(2)(f)(iv)

[redacted]

s 9(2)(f)(iv)

[redacted]

s 9(2)(h), s 9(2)(f)(iv)

[redacted]

s 9(2)(h), s 9(2)(f)(iv)

[redacted]

There are broader implications of making COVID-19 vaccinations mandatory, including the precedent effect

115 To date, the COVID-19 response has been built on clear, frequent communication; calling on people to do their part; and recognising their role in the team of five million. It has been a highly successful approach.

s 9(2)(f)(iv)

[redacted]

s 9(2)(f)(iv)

[redacted]

Financial Implications

121 The financial implications arising directly from the proposed approach in this paper will be met within the existing appropriation of Implementing the COVID-19 Vaccine Strategy Multi Category Appropriation until December 2021.

Legislative Implications

122 There are no legislative implications of the proposed approach.

Population Implications

123 The COVID-19 Immunisation Strategy and Programme aims to support the best use of COVID-19 vaccines, while upholding and honouring Te Tiriti o Waitangi obligations and promoting equity.

124 Our proposed approach to maximising uptake of the COVID-19 vaccine aims to achieve equity in uptake and access for Māori, Pacific peoples and other population groups by using different approaches to reach different groups, including:

124.1 tailored and culturally appropriate, communications to actively promote equitable uptake among Māori, Pacific peoples, and other population groups,

124.2 service design to remove barriers and improve access to vaccination for all, with particular focus on Māori, Pacific peoples, and other population groups

124.3 engaging and partnering with key stakeholders to deliver the programme and communicate with target groups (eg, using Māori and Pacific service providers).

125 The approach will support Te Tiriti by maintaining tino rangatiratanga in the choice to be immunised, partnering with Māori and Pacific peoples in the delivery and design of services, and reduces barriers and improves access to immunisation for all, especially Māori.

s 9(2)(h), s 9(2)(f)(iv)

[redacted]

127 While we expect most people to be able to be immunised (other than people receiving certain medications), people with certain health conditions or who are pregnant may not be able to be vaccinated.

Consultation

134 The Crown Law Office, the Department of the Prime Minister and Cabinet, the Treasury, Ministry for Business Innovation and Employment; Ministry of Transport; the Public Service Commission; Ministry of Primary Industries; Customs; and Ministry of Foreign Affairs and Trade have been consulted on the earlier policy advice that this Cabinet paper is based on. Due to time constraints they were not consulted on the Cabinet paper itself.

135 The Ministry of Health will continue to work with other agencies and key stakeholders on delivering the COVID-19 Immunisation Programme, and maximising uptake of COVID-19 vaccines.

Communications

136 The COVID-19 Immunisation Programme communications campaign is underway and will ramp up over 2021.

137 The overarching purpose of the public communications strategy is to build trust and confidence in the COVID-19 Immunisation Programme, which in turn will encourage uptake.

138 As part of this, we are working with a range of providers to design targeted approaches that will meet the information needs of New Zealand's diverse population, including border and MIQ workers.

Proactive Release

139 We do not intend to proactively release this Cabinet paper due to the fact that much of the advice is legally privileged and under active consideration.

Recommendations

140 The Minister for COVID-19 Response, Minister of Health and the Associate Minister of Health recommend that Cabinet:

1 Agree to the strategic and multi-faceted approach to maximise uptake of COVID-19 vaccines by border and MIQ workforces focused on:

1.1 stakeholder engagement and communication

1.2 service design and work to address barriers to uptake

1.3 reasonable application of levers under employment legislation

2 Note border agencies are working constructively together and with employers to encourage uptake of the vaccine without cost and set clear expectations of their workforces to be vaccinated

3 Note the Border Executive Board is expected to confirm, in the next week, whether further leave support is needed to maximise vaccine uptake in their employed and contracted workforces in Tier 1

s 9(2)(f)(iv)

s 9(2)(f)(iv) [redacted]

5 Note additional levers can be considered in the future if needed if the vaccine uptake in the border and MIQ workforces is not having the desired results

6 Note that officials will monitor and regularly report to Ministers on uptake of COVID-19 vaccines by Tier 1, how well the adopted approach is working and whether any changes are needed.

Authorised for lodgement

Hon Chris Hipkins
Minister for COVID-19 Response

Hon David Parker
Attorney-General

Hon Dr Ayesha Verrall
Associate Minister of Health

Appendix One: estimated constitution of Tier 1

It is estimated that Tier 1 of the Sequencing Framework consists of around 52,600 people (as at 2 February 2021). The estimate is subject to change as further engagements and data analysis is underway with the relevant agencies and stakeholder workforces to improve the accuracy of numbers.

This is made up of:

Workforce	**Number of people**
MIQ/MIF	4,885
Border/port	4,323
Border/airport	3,392
Household contacts (estimate only)	40,000
Tier 1 estimated total	**52,600**

Please note these numbers were based on early estimates and have since been superseded.

Appendix Two: Early analysis of indicative options to address work-related barriers to vaccination

Notes:

- The options below are based on early analysis prepared by the Ministry of Business, Innovation and Employment, with limited engagement with the Treasury and Ministry of Health. They are indicative and can potentially be used in combination.
- In this table, "access vaccination" means both receiving vaccination (including during work hours) and being able to recover from adverse reactions (up to a week) without having to work.
- ACC claims can be made for vaccine injuries that require more than a week off work.

	Option 1: Encourage all employers to support workers to access vaccination without cost/disadvantage *This is the approach being taken.*	**Option 2: Where Government is employer or contractor of services, allow workers to access vaccination without cost/disadvantage** *Note: Border Executive Board to confirm whether this is feasible in coming week.*
People whose vaccination this could most support	All tiers	All tiers; in particular/more immediately all Tier 1a workers
Pathway to implementation	Communications and public information campaigns, which could be led through employment channels and supplemented by public health messages.	Employment and contracting levers. For contracting levers, a decision may need to be made about how many contracting layers through which this assurance should be provided/sought.

s 9(2)(f)(iv)

[redacted]

Specific barriers addressed	People foregoing income as a result of being vaccinated, or foregoing vaccination if it means losing income, due to: • Difficulty accessing vaccination outside working hours • Lack of annual leave (for vaccination) • Lack of sick leave (for adverse reactions) • Employer hesitation to allow workers to access vaccination (eg, not offering paid special leave)		s 9(2)(f)(iv) [redacted]
Assumptions	This will align with public health messages about the desirability of vaccination. <u>For all options:</u> On-site vaccinations will take about 40 minutes each. If travel to a separate site for vaccination is required, this will take around four hours at most. Severe reactions of all types may happen in 1.1% of cases (this figure is very approximate), but these will not all be so severe as to require time off work.	Government will be able to use employment or contracting levers to allow workers to access vaccination without cost/disadvantage, including sick leave in case of adverse reactions.	s 9(2)(f)(iv) [redacted]
Benefits	Could prompt workplaces to support vaccine uptake. Support employers to do the right thing.	s 9(2)(f)(iv) [redacted]	

Drawbacks	Won't remove major barriers to access. Could fail to address equity implications based on people most likely to have work-related barriers to accessing vaccination (eg, people in precarious work).	May be complicated to achieve through contracting levers: may require contract variation, and examination of sub-contracting arrangements.	s 9(2)(f)(iv) [redacted]
Potential impact[2]	Nil to low. Most large employers already offer paid time off (through the form of workplace vaccination) in the case of influenza vaccination.	Low. Uptake is likely to already be high particularly in Tier 1a workforces. This option is likely to be pursued in combination with other options with more general application.	
Potential cost	Low, and likely to be met through existing baselines.	Low in total but could be felt acutely by particular employers (eg, MIQ) where there are already funding constraints.	

[1] **This is the approach that has been taken for the WSS, LSS and STAP.**

[2] **Further work is required to better understand specific barriers to vaccination for people in each tier, and therefore what the potential impact of each option could be (in terms of uptake that would not otherwise be able to be achieved)**

s 9(2)(f)(iv)

[redacted]

s 9(2)(f)(iv)

[redacted]