



COVID-19 Winter Surge Package 2022

Rapid Review

19 May 2023



Acknowledgements

Allen + Clarke recognises the substantial efforts of individuals involved in the COVID-19 response. At the time of this review, health officials have been in an operational response setting for over two years. We would like to thank all the people that contributed to this review for their time and input in a short space of time.

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EXECUTIVE SUMMARY

Background

On 14 July 2022, the Government rolled out the COVID-19 Winter Surge Package (the Winter Surge Package), which put in place a series of health measures to reduce the impact of COVID-19 and other seasonal illnesses on the health system. At the time Aotearoa New Zealand was experiencing a wave of Omicron cases combined with a spike in winter illnesses. This was placing significant stress on our communities and health and disability system.

The Winter Surge Package was introduced as part of additional public health measures to supplement the existing COVID-19 Protection Framework. When the measures were introduced Aotearoa New Zealand was at the orange setting, meaning some mandatory public health measures were in place. Mandatory measures included wearing of facemasks in many indoor settings and mandatory isolation for COVID-19 cases and household contacts.

The Winter Surge Package was stood up in a very short time to respond to the surge conditions. Minister Verrall requested advice on any additional measures on 4 July and final policy advice was provided on 8 July. The measures were implemented from 14 July onwards.

Approach

Manatū Hauora commissioned *Allen + Clarke* to complete an independent rapid review of the Winter Surge Package with a focus on identifying lessons learned for winter 2023.

The review was completed between 7 November and 12 December 2022. The Review Team reviewed available documentation and data, and conducted interviews with key stakeholders. Stakeholders represented a range of teams from across Manatū Hauora and Te Whatu Ora including policy, public health, COVID-19 communications and operational teams. We also interviewed stakeholders from Te Aka Whai Ora (3), Whaikaha (1), Department of Prime Minister and Cabinet (DPMC) (1), National Iwi Chairs Forum (2), and Iwi Communications Collective (1).

The findings of the review relied heavily on stakeholder views. The recommendations should be viewed in light of the rapid review period and the limited number and roles of stakeholders interviewed.

The scope of the review focuses on the views of Government officials. Communities were not engaged in the review. There is an opportunity to build on the findings of this review by further engaging with key stakeholders, such as primary and community care and Māori and Pacific providers as well as community groups.

Key Findings

- The Winter Surge Package was developed and operationalised within a short timeframe, to respond to winter surge conditions. The Winter Surge Package built successfully on existing relationships and planning across the sector.



- While this cannot be directly or solely attributed to the impact of the measures, data shows that after the measures were introduced the incidence of COVID-19 in the community steadily decreased as did COVID-19 hospitalisation rates.
- The table below provides a summary of the key measures that made up the Winter Surge Package and our findings in relation to each measure.



Table 1 – Summary of measures and findings

Measure	Data	Stakeholder comments	Findings
COVID-19 vaccination programme – specifically the roll-out of second boosters to those over 50	The number of booster vaccines being administered increased after this measure was introduced but remained slightly below target levels.	Planning for the roll-out of the second boosters was robust and well-coordinated. However, some stakeholders identified that public perceptions on the need for boosters could have limited the impact of this measure. This may have contributed to low uptake in those under 60 years.	<p>There was some increased uptake of vaccine boosters because of this measure.</p> <p>In future, there may be a need for more communications to emphasise the importance of boosters.</p> <p>In addition, future communications campaigns should include material designed specifically to support disabled people and tāngata whaikaha Māori to access vaccinations.</p>
Aligning the flu vaccination roll-out and COVID-19 vaccination programme	<p>There was a slight increase in flu vaccination rates for over 65s when combined with the COVID-19 vaccination.</p> <p>This provides some evidence that alignment may have increased uptake.</p>	Shifting the delivery of flu vaccines from primarily General Practice to delivery through pharmacies was effective and removed some barriers to access to the vaccine.	Aligning the flu and COVID-19 vaccines was an effective measure.
Free flu vaccinations for children aged 3-12	The data showed an upwards trend in the number of vaccinations after the measure was implemented.	Some stakeholders said that free vaccines to children aged 3 – 12 should have been implemented earlier in the season to have a greater impact.	Free flu vaccinations for children aged 3 – 12 was an effective measure.



Measure	Data	Stakeholder comments	Findings
Supply and distribution of facemasks to clinically vulnerable, high-risk individuals and children	There is insufficient data available to analyse the impact of facemasks as a stand-alone measure. However, supply channels were effectively and efficiently stood up in short time periods and there was a significant increase in the distribution of masks.	The distribution of facemasks through iwi and Pacific provider distribution channels was extremely effective. This measure was achieved easily as existing community hubs were used to distribute Rapid Antigen Tests (RATs) and perform polymerase chain reaction (PCR) testing.	Facemasks were distributed effectively via existing channels. Consideration should be given to whether these networks should be maintained longer term and to how to support independently funded disability organisations to efficiently supply masks, if needed.
Extra funding and supplies for schools and early childhood services to facilitate the use of facemasks in schools and support ventilation and winter heating	At the end of June 2022, the Ministry of Education (MOE) had provided more than 5,444 CO2 monitors to 2,457 schools and 8,300 portable air cleaners to 2,301 schools.	A few stakeholders recommended that ventilation could be considered in a broader range of settings as an important measure to reduce the spread of viruses including COVID-19 and influenza.	Insufficient data was provided to determine the efficacy of this measure.
Raising the supply of RATs to households	The supply of RATs remained sufficient throughout the winter period. However, there was not a significant increase in access to RATs after the measure suggesting they were already widely available to the public.	The removal of criteria to access RATs alongside the careful management of supply worked well to meet public demand. 12 stakeholders voiced concerns that RATs were made widely available too late, but this does not appear to be supported by evidence.	Data indicates that RATs were likely already widely available to the public, limiting the impact of this measure.



Measure	Data	Stakeholder comments	Findings
Therapeutics / antiviral roll-out (expanding eligibility for antivirals)	Data shows that expanding the access criteria in July and September had the most significant impact on the dispensed rate of antivirals.	Some stakeholders suggested that antivirals could have been made more widely available earlier which could have reduced pressures on primary care and hospitals. Pharmac did not approve wider use and approved use was staggered to meet demand. Data provided to the Review Team has been confined to the dispensed rate of antivirals so we cannot comment on whether expanding eligibility earlier would have led to supply issues.	Expanding eligibility for antivirals was effective at increasing uptake. Consideration could be given to further expanding eligibility including for disabled people without other qualifying medical conditions.
Therapeutics / antiviral roll-out (supply by pharmacies)	Approximately 400 pharmacies supplied antivirals directly to the public. However, the amounts supplied direct by pharmacies only accounted for 5% of total antivirals dispensed.	A few stakeholders noted that despite antiviral supply by pharmacies being an important tool, this measure was perhaps not implemented to its fullest. This was primarily due to short timeframes for implementation and subsequent limited uptake from pharmacies.	Making antivirals available via pharmacies was a good initiative that could be promoted more in future. This has the potential to increase access to antivirals for rural and priority communities.
Therapeutics / antiviral roll-out (back pocket prescriptions)	No data available.	Stakeholders viewed this measure as being less successful than other efforts to increase access to antivirals. Anecdotally, we understand that many GPs were reluctant to use back pocket prescriptions.	If this measure were to be adopted in future, further work should be put into coordinating with GPs to raise uptake and confidence.



Communications

There were some tools used as part of the winter-focused communications campaign which were seen as a significant success. These included:

- working with and through iwi based providers to disseminate messages in a way that was targeted to those communities, and
- specific targeting for Pacific Peoples with communications in specific languages and formats.

However, many stakeholders felt that the communications campaign was sluggish and could have been improved to be more consistent and better aligned with the information needs and behaviours of the intended audience. This included both priority groups and the general public. While the short time in which communications were required to be developed and disseminated presented a barrier to fully achieving this, there were many areas where stakeholders felt things could be done better in the future.

The main issues raised included:

- a lack of alignment between communications about policy settings and operational realities, such as messaging around availability of antivirals and actual availability of antivirals
- changes to aspects of the measures causing confusion, such as age eligibility for vaccination and General Practitioners (GP) providing 'back-pocket prescriptions' (where at-risk patients for acute respiratory illnesses could have pre-approved prescriptions ready, should they become unwell and need the medicine immediately) for pharmacies to dispense antivirals when this was not consistently offered in reality
- the continued focus on COVID-19 messaging, which was confusing and dominated other winter messaging such as messaging relating to the flu
- a lack of input from key perspectives such as Māori, Pacific peoples and tāngata whaikaha Māori during design and delivery of communications
- a need to recognise and support the effectiveness of community-led campaigns that responded to local unmet needs.

Equity response to Māori, Pacific peoples and tāngata whaikaha Māori and other priority populations

The development and implementation of the Winter Surge Package showed that equity was considered and that measures were targeted to priority populations, including Māori, Pacific peoples, immunocompromised people and elderly people. However, some stakeholders felt that the limited timeframe for advice to be provided and considered prevented robust equity analysis and engagement with communities on the particular measures taken as part of the Winter Package. While measures were implemented quickly in a targeted way due to existing relationships and ongoing equity analysis across the broader COVID-19 policy settings, a few stakeholders felt that more could have been done to better achieve equitable outcomes



through the Winter Surge Package. Many of the issues identified related to system wide considerations and approaches. These have been summarised at Appendix 4.

Other findings

- Many stakeholders felt the development of the Winter Surge Package was reactive and there would have been benefits to a more proactively planned surge response. In our recommendations we have identified key considerations to contribute to the success of this planning in future.
- Changes in the health system resulted in a less coordinated approach across agencies than would have been desired. In future, stakeholders feel there is greater scope for leadership from Manatū Hauora to give greater direction, ensure efforts are integrated and minimise confusion.
- Data analysis and modelling offered valuable insights into case and hospitalisation rates, at risk priority populations and the potential impact of removing measures. However, the speed at which the Winter Surge Package was developed meant that data analysis was not available to fully support all of the measures considered.

Recommendations

Looking forward to winter 2023, the health and disability sector will be operating in a different authorising and commissioning environment to that of winter 2022, following the establishment of Te Whatu Ora, Te Aka Whai Ora and Whaikaha. The health and disability system transformation will continue to take time to embed ways of working and ensure clarity of roles and responsibilities between agencies. This transformation sets the scene for the following recommendations.

1. The review was not able to make conclusive findings on the efficacy of any of the Winter Surge Package measures because insufficient data has been provided to support a robust analysis. However, we were able to identify areas where measures were likely effective and further research and planning should take place to strengthen these measures. These are outlined in Table 1.
2. Preparations for winter 2023 need to prioritise a clear and timely communications campaign. This will be the main way to encourage behaviours and to inform people of any measures to adopt. The communications campaign should:
 - a. be framed generally to apply to winter illnesses and promote good public health measures
 - b. be informed by data on public perceptions and virus-spread
 - c. be sufficiently resourced and planned to provide cohesive and clear messaging
 - d. contain targeted messaging, developed in partnership with, and for, priority populations.
3. Robust and timely winter surge planning is needed for 2023. This should:



- a. include preparedness for a broad range of illnesses – not just COVID-19
 - b. have clear objectives
 - c. be supported by modelling and evidence
 - d. consider healthcare challenges across all levels of health settings (primary, secondary and community care)
 - e. have early input from communities, especially priority communities such as Māori, Pacific and disabled people.
 - f. have targeted communications available for priority communities in accessible formats at the same time as general messaging.
4. The health system must partner with communities to achieve equitable outcomes. In the winter response period, existing partnership arrangements responded well to the pressures of the winter period and were able to quickly and efficiently implement the measures. Consideration needs to be given to building and strengthening these partnerships long-term.
5. To meet obligations under Te Tiriti o Waitangi, Māori need to be considered equal and/or lead partners in policy development and implementation. An example of where this worked well was the Māori Providers Distribution Channel – which included Māori leadership from planning through to implementation.

1.0 INTRODUCTION

1.1 Background

Context for the Winter Surge Package

Leading into winter 2022, officials understood that there would likely be challenges to our health system arising from a combination of pressures from COVID-19 cases and other seasonal illness.

The Winter Surge Package was introduced against the backdrop of a range of public health protections and preparations including:

- The COVID-19 Protection Framework was in place and Aotearoa New Zealand had been at the orange setting since 13 April. This required facemask wearing in many indoor locations and mandatory self-isolation of cases and household contacts for 7 days.
- Winter planning and surge responses were in place at the District Health Board level including plans to respond to increased demand for emergency services and the impact of staff illnesses.
- A winter communications campaign focussing on key messages for winter wellness was in place. The campaign was run out of Department of the Prime Minister and Cabinet's (DPMC) Unite Against COVID-19 channel.

Despite these measures, Aotearoa New Zealand experienced a surge of COVID-19 cases driven by the B.1.1.529 variant of Omicron. The variant spread across the country alongside levels of seasonal respiratory illnesses, placing a significant burden on our communities and the health system.

In early June DHBs reported¹ that they were experiencing significant impacts from this winter surge including:

- high levels of staff absenteeism (primarily as a result of illness)
- challenges managing high levels of patient flow
- increased GP waiting times
- resulting disruptions in delivery of planned care.

The policy response

On 4 July 2022 Minister Verrall requested officials to consider additional public health measures that could be put in place alongside the COVID-19 Protection Framework (CPF).

¹ Memo from Dr Jim Miller, Acting Director of Public Health to Dr Ashley Bloomfield – *Review of COVID-19 Protection Framework settings and isolation periods – 15 June 2022 – Appendix 1 – DHB assessments.*



This meant measures to be considered were limited to those outside the CPF and did not include any mandatory measures or settings managed under the CPF such as isolation periods or gathering limits.

On 8 July 2022 Manatū Hauora provided advice to Minister Verall on a range of public health measures which were designed to respond to the winter challenges. As further mandatory measures were out-of-scope, policy thinking was framed around behavioural levers – encouraging people to act in ways to prevent the spread of illness and providing people access to the tools and information needed to do this. Specific measures were targeted at reducing the rates of flu and COVID-19.

The key measures that made up the Winter Surge Package and are within the scope of this Review included:

- the COVID-19 vaccination programme – specifically the second roll-out of boosters to those over 50
- aligning the flu vaccination roll-out and COVID-19 vaccination programme
- free flu vaccines for children aged 3 – 12
- supply and distribution of facemasks to the general public and school staff and children, and P2 / N95 masks to clinically vulnerable and high-risk individuals
- extra funding and supplies for schools and early childhood services to facilitate the use of facemasks in schools and support ventilation and winter heating
- increasing the supply of RATs to households
- winter-focused communications campaign
- therapeutics / antiviral roll-out including expanding eligibility for antivirals, making COVID-19 medicines available in pharmacies and back-pocket prescriptions.

Further information on the key measures is outlined at Appendix 1. Throughout this report these settings will be collectively referred to as the Winter Surge Package or the measures.

On 14 July the Government announced the Winter Surge Package to the public and the measures were implemented.

1.2 Purpose

Allen + Clarke was commissioned to complete an independent rapid review of the health and disability sectors response to the wave of COVID-19 cases that occurred in the winter of 2022.

The primary purpose of the review was to identify ‘lessons learned’ which can be applied to preparation for winter 2023 and future waves of COVID-19.

The focus of the review was on the health response, primarily the activities of Manatū Hauora and Te Whatu Ora (including the relevant interface with DPMC). The scope did not include actions and responsibilities of other Government departments or activities at local



levels. Input from Te Aka Whai Ora and Whaikaha was sought in relation to lessons learned for supporting and enabling equitable outcomes for vulnerable population groups.

1.3 Scope

The scope of the review was limited to the key measures which formed part of the Winter Surge Package outlined in the following section.

The review focused on six key questions:

1. What were the policy settings which applied to this area?
2. What actions were carried out over the period in scope?
3. Comment on how these policies and actions contributed to relieving health and disability system pressures and protecting New Zealanders from the effects of the Winter surge 2022. The report should consider and where relevant comment on planning, policy settings and execution and also coordination within individual agencies and also between agencies.
4. What lessons can be taken from the experiences in 2022 about how best to prepare for a winter surge in 2023?
5. How did these actions contribute to equitable outcomes for vulnerable groups in the population, including Māori, Pacific, disabled people, children and older people?
6. What priority should be given to lessons learned from 2022?

The scope of the review did not include:

- other COVID-19 policy settings (such as the COVID-19 Protection Framework)
- wider usual winter preparedness in the health system
- planning for and responding to the impact of increased numbers of healthcare workers having to isolate as household contacts during the winter surge.

Most stakeholder interviews gave rise to general commentary on the health system response to COVID-19 which was outside of our scope. This was particularly the case when considering wider equity issues within the health system. These issues have been discussed where we consider there was impact or applicability to the Winter Surge Package.

1.4 Approach

Allen + Clarke undertook the review between 7 November and 12 December 2022. We relied on a review of available documents and data together with interviews with staff from Manatū Hauora, Te Whatu Ora, Te Aka Whai Ora, Whaikaha, the National Iwi Chairs Forum and DPMC.

In total 51 stakeholders were interviewed including:



- 19 people from Manatū Hauora representing a range of teams including:
 - Systems, Strategy & Policy
 - Science & Technical Advisory
 - Māori Health Directorate
 - System Performance Priorities
 - Intelligence and Analytics
 - Science & Technical Advisory
 - System Performance & Monitoring
 - COVID-19 Communications
- 22 people from Te Whatu Ora representing a range of teams including:
 - National Immunisation Programme
 - National Co-ordination and Response
 - National Investigation and Tracing Centre
 - Outbreak Response
 - Care in the Community
 - National Public Health Service
 - Hospital and Specialist Services
 - COVID-19 Health System Response – Testing and Supply
- 3 people from Te Aka Whai Ora
- 1 person from Whaikaha
- 1 person from DPMC from the Communications and Public Engagement team
- 2 representatives of the National Iwi Chairs Forum
- 1 representative of the Iwi Communications Collective
- 1 representative from the former Auckland DHB.

A comprehensive list of stakeholders interviewed is provided at Appendix 2.

Initial discovery documents were provided by the COVID-19 Policy Response Team and other stakeholders were asked to provide additional documents to support the review. The list of documents reviewed is provided at Appendix 3.

A reference group of officials from respective agencies met with the Review Team weekly and provided oversight and feedback throughout the review process.



1.5 Limitations

The findings of this Review should be considered in context of the approach and timeframes.

- Due to time constraints the Review was completed through desktop review of documents and available data and interviews with a select group of people – mainly officials.
- While the Review Team reviewed documents when provided, we relied heavily on the opinions of interviewees. We have identified throughout the report where opinions were held by some, many or all of the interviewees.
- Given the timeframes and the transition to new health agencies, some key individuals were not available for interviews. Since the transition to the new health agencies there has been a significant turnover of staff and shift in roles and responsibilities. A significant theme throughout our engagement was that many stakeholders felt that other parties who were no longer at Manatū Hauora or Te Whatu Ora would have been better placed to answer our questions. A decision was made in consultation with Manatū Hauora that we would only pursue interviews where the interviewee was still employed in one of the central health agencies. Only one stakeholder with a specific Pacific focus was able to be interviewed.
- Our review relied on data collected by Manatū Hauora. While the data provided some insights to the effectiveness of some measures, it did not cover the full breadth and scope of the Winter Surge Package. There were also some limitations in available disaggregated data relating to vulnerable groups such as disabled people and tāngata whaikaha Māori.²
- The approach identifies lessons learned from the perspective of officials and the Government's existing data sources but primarily provides a Government perspective on the efficacy of the Winter Surge Package. Other information and data sources such as those listed below would provide valuable insights for future planning and activities.
 - A community-based review which evaluates the impact of the package on communities including schools, disabled community, Pacific peoples, whānau, iwi and hapū.
 - A primary health provider-focused review to understand the impact of the package on the primary health sector. From an equity perspective, we would recommend a particular focus on Māori and Pacific providers and networks.
 - A survey of local hospitals / locality information to supplement existing data sets made available for the review.

² National Health Index (NHI) is used to identify people who use health and disability support services. Disability is not currently identified in the NHI meaning that most COVID-19 reporting is unable to include data on disabled people. This has contributed to limited evidence available regarding the direct impacts of COVID-19 on disabled people in Aotearoa New Zealand such as infection, hospitalisation and mortality rates, access to therapeutics and vaccination coverage.



1.6 A note on the health and disability system reforms

On 1 July 2022, Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (Māori Health Authority) were established as statutory entities to operate in partnership with Manatū Hauora. The transformation involved a realignment of core functions including the transition of many COVID-19 related response functions from Manatū Hauora to Te Whatu Ora.

Practically, this meant that winter strategic and operations planning started with Manatū Hauora and DHBs. However, after 1 July Te Whatu Ora took responsibility for operational implementation.

The resulting shift of personnel, roles and responsibilities had a significant impact across the health and disability system. For our review, it meant we were often unable to identify people who had ongoing involvement with the Winter Surge Package from planning through to implementation.

A clear theme throughout our engagements was a period of turbulent change and transition, with significant changes in roles and responsibilities which hindered smooth coordination from planning through to policy and implementation.

Given the risks associated with commencing the reforms during a pandemic were well known and steps taken to mitigate these we have tried to focus commentary on areas where role clarity and co-ordination between the agencies will have benefits for winter planning for 2023.

2.0 KEY FINDINGS – THE EFFECT OF THE WINTER SURGE PACKAGE

Overall, the Winter Surge Package was able to be operationalised within a short timeframe given existing relationships and planning across the sector.

Given the other public health measures in place at the time it is not possible to determine how effective any of the Winter Surge Package measures were in isolation. However, we have provided data below which supports the conclusion that public health measures in place from June contributed to a decrease in COVID-19 cases and hospitalisations.

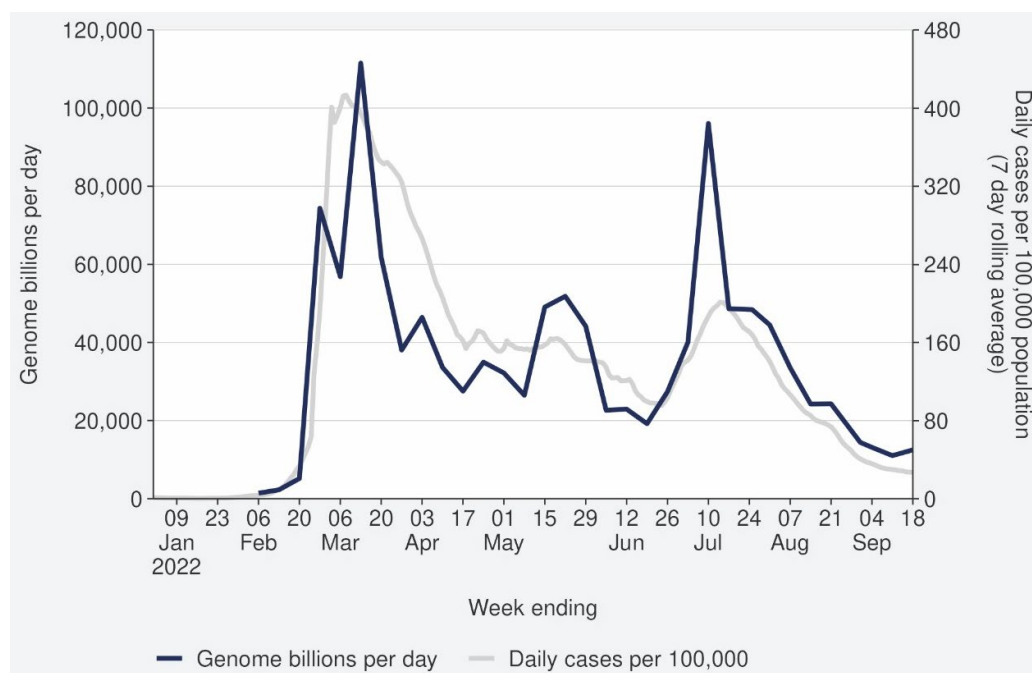
In section 3.0 we have commented on the data available in relation to individual measures.

Rates of COVID 19 in the community

As of 23 September 2022, both national wastewater data and reported cases showed a steady decline in the rates of COVID-19 in the community from a peak in cases in July.

During 2022, reporting of COVID-19 predominantly moved to self-reporting of RATs taken at home. It was suspected that this led to the under-reporting of COVID-19 cases over winter 2022. In order to mitigate this, wastewater detection was overlaid with self-reported cases to give a more nuanced analysis about case numbers. This will likely be an ongoing challenge as RATs are likely to become the predominant form of testing for COVID-19.

Figure 1: Daily cases per 100,000 population comparison of wastewater and reported cases

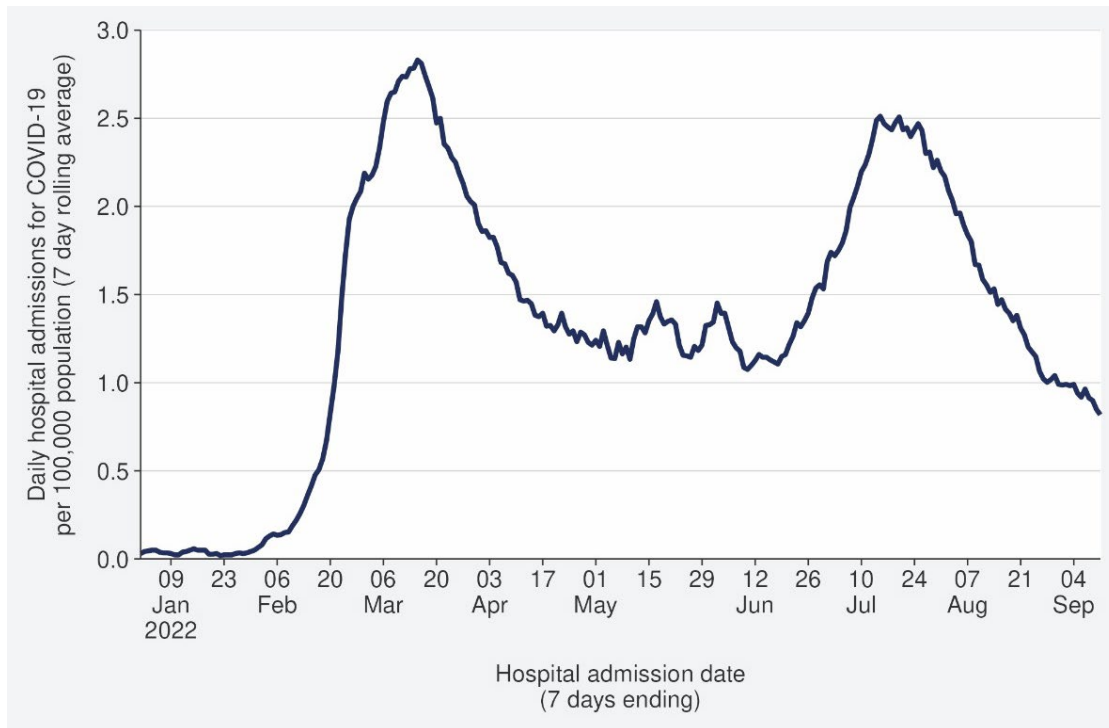


Hospitalisation rates

Hospital admission rates for COVID-19 (anyone admitted to hospital testing positive for COVID-19) decreased after a peak in mid-July to a 7-day rolling average of 0.8 per 100,000 of population in week ending 11 September.



Figure 2: National Hospital Admission Rates for COVID-19 February to September 2022





3.0 KEY FINDINGS – PER MEASURE

As outlined previously the measures were able to be operationalised within a short timeframe given existing relationships and planning across the sector.

This section provides a high-level analysis on the efficacy of individual measures based on a combination of the available data and the perspectives of stakeholders. Recommendations are based heavily on stakeholder perceptions of the efficacy of the measures.

3.1 COVID-19 vaccination programme – roll-out of second booster to over 50s

3.1.1.1 Evidence – uptake

In June 2022, the number of boosters being administered to the public was declining. Following the Winter Surge Package, the number of boosters started to trend upwards and in early September, 17,396 second boosters were being administered in a 7-day period. The numbers of boosters being administered started to trend downwards again by September 2022.

Data shows that Māori had the highest rates of uptake of the second booster compared with Pacific people and non-Māori. However, the rate of uptake was still only 24.4%, which is considered low.

As at 26 September 2022, 38% of the total population aged over 50 years had received their second booster. More Māori and Pacific people aged 50 – 64 had received their second booster than the rest of the population.

We note that people who had experienced COVID-19 were required to wait at least three months before receiving a booster, which may have contributed to reduced uptake.

Table 2: COVID-19 Booster 2 Eligibility & Uptake (26 September 2022)

COVID-19 Booster 2 Eligibility & Uptake	# people eligible for 2nd booster	# people given 2nd boosters	Uptake %
Māori	73,956	18,032	24.4%
Pacific Peoples	37,560	8,788	23.4%
NMNP	591,187	122,849	20.8%
50 to 64	702,703	149,669	21.3%
Māori	45,838	20,445	44.6%
Pacific Peoples	21,910	8,536	39.0%
NMNP	651,429	362,890	55.7%
65+	719,177	391,871	54.5%
Total 50+ Age Group	1,421,880	541,540	38.1%



3.1.1.2 What we heard

Initiatives to support uptake

Stakeholders identified a number of initiatives that they viewed as successful in supporting the uptake of boosters. These included:

- Mobile outreach teams in Te Tai Tokerau supported by GPs which provided booster appointments onsite. This eased the pressure on GP appointments.
- A range of publications including Pacific-focused collateral in Tongan, Samoan and English was also developed and distributed as part of the “Five Reasons to Get Your Booster” campaign. One stakeholder noted the success of the ethnic specific targeting within the Pacific population.

However, despite the increased uptake in boosters through the Winter Surge Package some stakeholders felt that there were some barriers to fully achieving the impact desired from this measure.

Eligibility for boosters

Many stakeholders reported that there was confusion in the communications around eligibility for the second booster. Stakeholders attributed this to confusing communications – although anyone over 50 was eligible for a booster, the communications were targeted at more vulnerable groups.

Roll-out of the boosters

Stakeholders generally felt the roll-out of second booster was successful, although uptake was not high compared to other vaccinations.³ The roll-out was more difficult than anticipated because the high level of apathy towards the vaccine had not been predicted.

Some stakeholders felt there was a missing link between vaccines being ready and available and the delivery of these to the public. We heard that without vaccine centres it was harder to access vaccinations as people had to make appointments with their doctor. However, most stakeholders felt the roll-out of vaccines through pharmacies worked well and empowered pharmacies to be a more active part of the COVID-19 response. Originally there was some concern that opening eligibility for the second booster would overwhelm pharmacies, but this did not eventuate.

3.1.1.3 Lessons learned / Recommendations

In future, eligibility and availability of vaccine boosters should be more clearly communicated to the public to ensure there is no confusion over who is eligible.

³ This is reflective of global trends.



Future vaccination roll-outs need to be supported by comprehensive implementation and planning, including targeted messaging for disabled people (alternate formats and digital accessibility).

3.2 Aligning the flu vaccination roll-out and the COVID-19 vaccination programme

As part of the Winter Surge Package flu vaccinations were offered to eligible people alongside COVID-19 vaccinations.

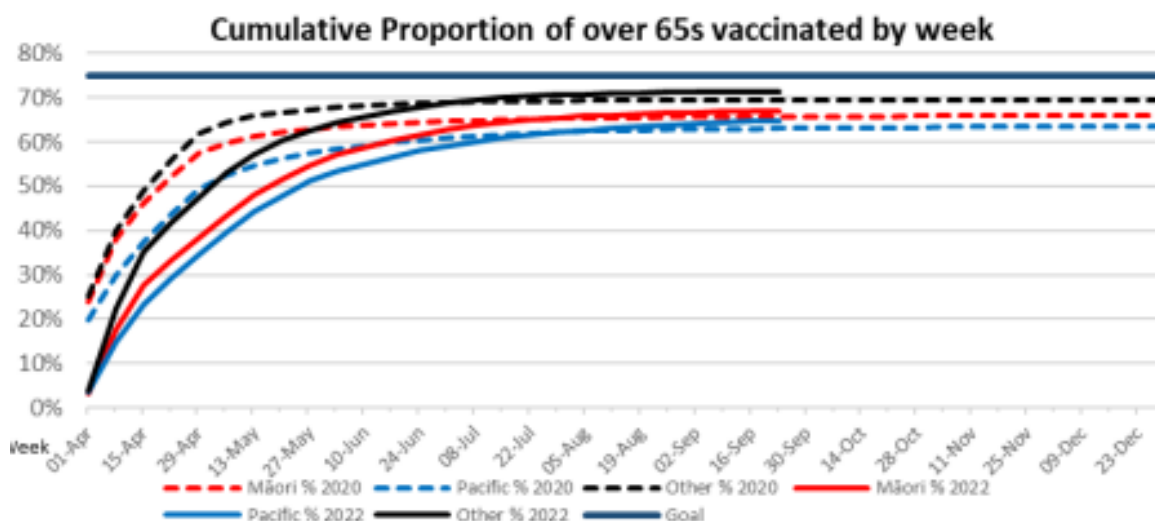
3.2.1.1 Evidence – uptake

We have only received data relating to uptake of the flu vaccination in over 65s. While some insights can be taken from the uptake of the flu vaccination over this period, we cannot necessarily link this with the measure. Data for over 65s was captured and reported on as this is a key age group which is at risk of severe impacts from flu and benefit significantly from vaccination.

Over 65s

As at 26 September 2022, 70.9% of people aged 65 years and older had received a flu vaccination.

Figure 3 Proportion of over 65s by ethnicity vaccinated by week



Compared with 2020 this is a slight increase across all groups, although vaccination rates are still below the target of 75%.

Māori and Pacific over 65

Targeted messaging and engagement with iwi and Pacific providers and communities was undertaken during the winter period. As at 26 September 2022, the equity gap for over 65s across all population groups had reduced to 4.4%.



Figure 4: Flu vaccinations in over 65s by ethnicity by DHB

DHB	Total %	Māori %	Pacific %	Other %	Asian %	Equity gap (Māori)
Auckland	68.8%	67.6%	63.6%	72.2%	61.7%	-1.7%
Bay of Plenty	72.1%	65.6%	60.1%	73.4%	55.6%	-7.4%
Canterbury	78.2%	77.1%	69.2%	78.9%	65.8%	-1.2%
Capital and Coast	73.7%	71.0%	68.8%	75.1%	65.1%	-3.1%
Counties Manukau	67.1%	67.1%	65.6%	69.9%	61.2%	-0.2%
Hawkes Bay	74.5%	67.4%	69.3%	75.8%	59.0%	-8.1%
Hutt Valley	72.0%	67.4%	69.3%	73.3%	65.4%	-5.1%
Lakes	65.1%	62.9%	57.5%	66.1%	51.6%	-2.7%
MidCentral	73.5%	68.5%	66.3%	74.2%	66.7%	-5.4%
Nelson Marlborough	71.6%	70.6%	73.8%	71.7%	63.5%	-1.1%
Northland	65.6%	63.2%	63.4%	66.2%	55.1%	-2.9%
South Canterbury	75.3%	69.4%	68.6%	75.6%	55.8%	-6.0%
Southern	71.0%	71.4%	71.1%	71.1%	60.5%	0.5%
Tairāwhiti	68.0%	69.3%	63.0%	67.6%	56.0%	1.9%
Taranaki	72.4%	69.5%	66.7%	72.8%	60.9%	-3.1%
Waikato	67.9%	62.1%	61.3%	69.3%	55.6%	-6.5%
Wairarapa	74.6%	66.2%	72.8%	75.3%	62.9%	-9.0%
Waitemata	66.4%	65.3%	58.0%	68.7%	58.1%	-1.5%
West Coast	68.1%	68.7%	77.8%	68.1%	57.1%	0.7%
Whanganui	77.0%	73.4%	75.4%	77.6%	65.8%	-4.0%
NA	107.5%	82.3%	128.6%	102.5%	160.0%	-27.0%
Total	70.9%	67.0%	64.8%	72.4%	61.1%	-4.4%

3.2.1.2 What we heard

Stakeholders were generally positive about the implementation of the flu vaccine and noted the increase in uptake. Many felt this would be a key measure for any future winter package and noted some areas which could be improved to achieve an even greater impact.

Combining the vaccines

Most stakeholders commented that from an operational perspective, it makes sense to combine the flu and COVID-19 vaccine into one concomitant vaccine. However, care needs to be taken to ensure that people want to receive both vaccines. As discussed further under communications, there is some evidence to suggest greater hesitancy over the COVID-19 vaccine than the flu vaccine.

Impacts on accessibility

Most stakeholders felt that aligning the flu vaccine with the COVID-19 vaccine increased the accessibility of vaccines for the public. Shifting the delivery of flu vaccines from GPs to delivery through pharmacies was effective. Pharmacies are more accessible as people can turn up without an appointment and are more accessible in some rural areas.

Eligibility criteria

We heard from some stakeholders that the misalignment between eligibility for the two vaccines was a source of frustration and acted as a barrier to the roll-out. Further, different eligibility for Māori and Pacific peoples caused confusion in vaccinators and in the public. There was a public health rationale for the different eligibility criteria, but this was not clearly communicated or understood across the system.

Supply of vaccines

We heard that the supply team was unable to access flu vaccines in time to link this with boosters. With additional planning, advance notice could have been given to vaccine



suppliers to indicate a desire to bring forward the flu vaccines. Flu vaccines arrived later in the winter period which reduced their efficacy as a preventative measure.

3.2.1.3 Lessons learned / recommendations

There is an opportunity to continue to work with pharmacies to ensure they can be involved in future roll-out of flu and COVID-19 vaccinations.

Eligibility criteria need to be clearly communicated and further consideration should be given to aligning eligibility. This will involve coordination between the clinical teams responsible for setting criteria, as well as clear collaboration between communications teams and delivery teams to ensure both health workers and the public are aware of who is eligible for a vaccine.

Planning for vaccine roll-outs needs to happen further in advance so supply levels match demand.

3.3 Free flu vaccines for children aged 3 – 12

The decision was made to offer free flu vaccinations to 3 – 12-year-old children as data shows they are more at risk of negative impacts from the flu. Flu is the most common cause of admission to hospital in this age group in winter.

3.3.1.1 Evidence – uptake

Data shows there was an increase in the uptake of the flu vaccination for this age group after the measure was introduced. This provides some evidence that the measure was effective in increasing uptake.

Table 3: Vaccination rates in 3 – 12-year-olds (all ethnicities)

Dates	Cumulative number of children vaccinated
Pre-28 June 2022	26,223
Post-28 June 2022	32,485

3.3.1.2 What we heard

Messaging

Most stakeholders felt that the flu vaccine was made free too late in the season to truly effect uptake of the vaccine. Messaging on the vaccine being free started during winter rather than before and it was suggested earlier messaging would have allowed for greater awareness and uptake. The flu is not widely recognised among the public as a risk for children, and there is a need for better communications to families and whānau on why children will benefit from the flu vaccine. It was suggested that more could have been done to promote the campaign, particularly with the focus on parents and the education sector. A positive initiative in this



space was the monthly webinars for the education sector run jointly by the clinical team and paediatricians, with approximately 150 attendees each month.

3.3.1.3 Lessons learned / Recommendations

Planning and messaging of flu campaigns are vital to uptake

Annual planning for flu campaigns should be completed in a timely fashion to allow for sufficient engagement and promotion of measures. Earlier and stronger engagement with a family focus would have allowed parents to consider the vaccination and provide details about the risks of flu to children. This would also have improved the efficacy of the measure as it would have created higher immunity in the early winter months.

3.4 Supply and distribution of facemasks to clinically vulnerable, high-risk individuals and children

This measure involved the following activities:

- Supporting New Zealanders to wear masks, with 16 million medical procedure masks and over 3 million P2 / N95 masks being distributed over June / July 2022.
- Te Whatu Ora supplying a wide range of providers with free medical masks and P2 / N95 masks, including Māori and Pacific distribution channels, disability providers, Ministry of Social Development, Ministry of Pacific Peoples, Te Arawhiti and the personal protection equipment portal.
- Te Whatu Ora supplying extra medical masks to aged residential care villages and facilities, primary care, hospice, cancer and leukaemia societies, and Grey Power for further distribution.
- Providing free packs of medical masks (along with free RAT kits) for individuals and households, regardless of COVID-19 symptoms, from testing centres and other locations. Having medical masks and P2 / N95 masks available at testing centres, with P2 / N95 masks provided to people at higher risk of severe illness from COVID-19.
- MOE directly providing 10 million child-size masks for year 4-7 students and up to 30,000 masks a week for all other students and school staff⁴.

Available New Zealand data and research does not enable an analysis of the impact of facemasks as a stand-alone measure (including the use of P2 / N95 masks versus surgical masks). Overseas comparators and analysis were primarily relied on as an indicator of the effectiveness of facemasks in reducing the spread of COVID-19.

⁴ Manatū Hauora Aide-Mémoire, Meeting with Vaccines Plus NZ representatives.



3.4.1.1 What we heard

Distribution

The distribution of facemasks was seen by many as one of the best implemented measures of the Winter Surge Package. Supply and distribution channels were mobilised and stood up quickly enabling rapid and efficient distribution.

We heard from many stakeholders that the distribution of facemasks through existing iwi and Pacific provider channels was extremely effective. This system allowed providers to order what they needed and get pallets delivered for them to distribute. These existing networks had been built up over the course of the pandemic but were able to easily and quickly adjust to increased demand in the winter period. Moving forward there were concerns that some distribution sites are being shut down which may hinder the ability of these networks to respond quickly in future.

However, one stakeholder we spoke to suggested that the supply of facemasks was not needed. They felt that facemasks were already widely available in the community, demonstrated by a short surge in orders which quickly tailed off.

Whaikaha reported that the supply of face masks for disabled people was variable – some disabled people had good access, while other disabled people did not know how to source facemasks.

Storage

We heard that some disabled people's organisations and home and community support services were unable to store large pallets due to being small organisations with limited resource, such as storage space.

3.4.1.2 Lessons learned / Recommendations

We know that facemask-wearing and ventilation will likely continue to be one of the key measures to prevent spread of a range of viruses. Future winter messaging should emphasise the importance of facemask-wearing as a prevention against a range of illnesses (not just COVID-19).

Assuming an ongoing emphasis on facemasks, there is a need to invest in storage and distribution networks to ensure they can provide supply on a long-term basis. In particular, the success of community networks in quickly distributing facemasks justifies considering long-term partnerships with these organisations.

There needs to be greater systems thinking on centrally coordinated distribution for small organisations, such as disabled people's organisations and home and community support services. This should be supported by small organisations being notified of local storage and distribution mechanisms rather than having to establish these systems themselves.



3.5 Extra funding and supplies for schools and early childhood services to facilitate the use of facemasks in schools and support for ventilation and winter heating

This measure involved MOE directly providing the following:

- 10 million child-size masks for year 4-7 students and up to 30,000 masks a week for all other students and school staff, alongside extra funding to support better ventilation over the winter.
- Supplementary funding to schools and centre-based early childhood services to offset the heating costs associated with natural ventilation over the winter months.
- Access to CO₂ monitors and portable air cleaners for early childhood services.

As at the end of June 2022, MOE had provided more than 5,444 CO₂ monitors to 2,457 schools and 8,300 portable air cleaners to 2,301 schools⁵.

3.5.1.1 What we heard

Very few stakeholders had specific knowledge about this measure and how this intervention worked. It was generally felt that it was a very important measure and anecdotally some stakeholders thought it had broadly worked well.

Public health stakeholders thought that the importance of ventilation could have been considered earlier in the winter response and felt there was a lack of ownership around ventilation guidance. Some stakeholders commented that coordination between Manatū Hauora, MOE and the Ministry of Business, Innovation and Employment (MBIE) was poor with high levels of confusion and conflicting advice. We understand that MoE commenced work to distribute air purifiers to at-risk schools in 2022 and will continue this in 2023.

3.5.1.2 Lessons learned / Recommendations

There is an opportunity to better engage with schools and early childhood services to understand the implication of potential challenges in ensuring children are protected against the spread of COVID-19 as they are best placed to respond to their respective school environments.

There is an opportunity to consider ventilation in a broader range of settings, as part of the overall health system response. For example, early observations from Italy demonstrated the spread of COVID-19 through medical waiting rooms. This would require cross-agency and cross-sector work, including involvement from MBIE and MOE.

⁵ Manatū Hauora Aide-Mémoire, Meeting with Vaccines Plus NZ representatives.

Disabled people have suggested using decal (a type of sticker that is durable) or signage to provide the disabled community with assurance that a facility has adequate ventilation systems in place. Disabled people also seek information about best-practice ventilation systems and assurances of where these standards are being applied.

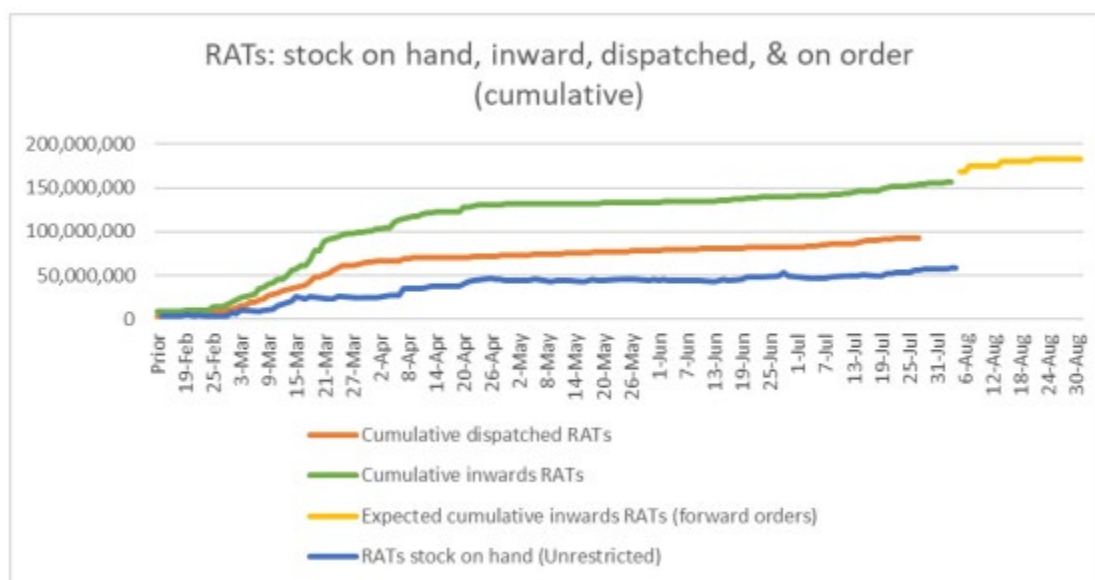
3.6 Raising the supply of RATs to households

The Winter Surge Package enabled RATs to be distributed to anyone in the community regardless of whether they were symptomatic. The purpose was to give individuals the ability to make their own risk assessments with rapid results.

3.6.1.1 Evidence – raising supply

The increased distribution of RATs was a success in terms of providing improved access to RATs for a greater number of households. The demand for RATs from the public peaked in July 2022 and has tapered off since then, with occasional peaks and troughs. Supply remained sufficient throughout the winter period to satisfy demand, and distribution networks worked efficiently with the ability to stand up additional contractors where required to meet short term peaks.

Figure 5: RATs stock and distribution



3.6.1.2 Evidence – impact of raised supply

While the distribution of RATs worked well, it is less clear whether they were used effectively. Data shows a decrease in the number of cases being reported coincided with an increase in hospitalisation (which seems unlikely). However, it was possible that tests were being completed but positive results were not being reported.



3.6.1.3 What we heard

Most stakeholders felt the removal of criteria to access RATs alongside the careful management of supply worked well to meet public demand. The ability to track supply meant there were no concerns about running out of supply and enabled the removal of access criteria.

The distribution of RATs through these existing channels was extremely effective. This system allowed providers to order what they needed and get pallets delivered for them to distribute. These existing networks had been built up over the course of the pandemic but were able to easily and quickly adjust to increased demand in the winter period. There were concerns that some of distribution sites are being shut down which may hinder the ability of these networks to respond quickly in future.

However, some stakeholders voiced concerns that RATs were available too late. Early winter modelling was showing a rise in cases, but RATs were not widely accessible at this time in the right places.

Looking to the future, the supply team raised questions about the sustainability of distribution channels. As of 4 August 2022, there were 300 sites offering RAT collection including community collection sites, Community Testing Centres and 130 providers supporting priority population groups. However, a large number of these sites are being disestablished. Pharmacies, GPs and other existing channels may not have the same capacity to store large volumes of RATs to respond to surges in demand.

3.6.1.4 Lessons learned / Recommendations

Planning for 2023 needs to consider how RATs will be distributed without the current network of distribution channels, assuming that public health advice continues to support their usage. Existing community networks were extremely successful in distributing RATs to priority populations, and there may be benefits to maintaining and strengthening these networks.

The keys to the successful roll-out of RATs was visibility of supply, and clear and transparent reporting about demand and supply.

3.7 Winter-focused communications campaign

Background

Winter-focused communications campaigns were delivered by both DPMC (via Unite against COVID-19) and Te Whatu Ora. This report focuses on the winter campaign delivered by Te Whatu Ora, however, we have also considered the overlap or interaction between the two communications campaigns.

The winter-focused communications campaigns were additional campaigns that were intended to promote and reinforce opportunities for the public to keep themselves well in the context of a range of winter viruses. Both campaigns were no longer COVID-19 centric but focused on the range of common winter illnesses. The campaigns focused on public health measures such as facemask-wearing, hygiene practices and staying home when sick.



The winter-focused communications campaign was highlighted by almost all stakeholders as a crucially important part of the Winter Surge Package. In the absence of mandatory measures under the COVID-19 Protection Framework, the communications campaign was the primary method to encourage general health protection measures and to support uptake of the flu vaccination.

Stakeholders commented on the importance of communications in providing factual, trusted information, education and awareness raising for the general public.

Activities undertaken

Communications and engagement staff drew on research and insights undertaken by The Research Agency to inform development of the Te Whatu Ora campaign. This included general and priority population insights including:

- Māori communities
- Pacific peoples
- people with health conditions
- people aged over 65
- disabled people
- pregnant women.

We heard that significant consideration was given to how to frame messaging focusing on influenza within a communications environment that had been dominated by COVID-19 messaging. Research⁶ suggested that priority populations had greater hesitancy and anxiety over COVID-19 vaccinations but were more familiar with and likely to accept the flu vaccine. This guided an intentional approach to market the COVID-19 vaccination and flu vaccination separately.

There was a two-phase, multi-channel approach taken with distinct messaging across relevant channels including:

- targeted messaging to priority populations who were eligible for a funded flu vaccination. This included a direct campaign (via SMS, email or physical letter), radio (including culturally and linguistically diverse stations) and digital targeting to provide a personalised call-to-action
- general public messaging focused on television commercials and other channels to raise general public awareness of the winter messaging.

There was a high level of interest in receiving information about the influenza immunisation during the late-July and early-August period. There was a significant reduction in uptake of the free flu vaccination and traffic to the Te Whatu Ora website in early-August after advertising finished at the end of July.⁷

⁶ The Research Agency 2022 Flu State of the Nation.

⁷ Te Whatu Ora Flu 2022 Campaign Activity Summary.



3.7.1.1 What we heard

While it was acknowledged that communications for the Winter Surge Package were developed and rolled out in a very short timeframe and with challenging and rapidly changing public sentiment, many stakeholders noted that there were some areas which could be improved to significantly increase buy in to key messages. These stakeholders felt that communications were going to become even more imperative going forward with a focus on individual responsibility and made suggestions for improvement.

Oversaturation of COVID-19

Despite efforts to shift to general winter messaging, there remained a clear media and public focus on COVID-19. Some stakeholders expressed concerns that communications induced a degree of anxiety, fear and / or panic among the public to drive behavioural changes. There were mixed views among stakeholders about the appropriateness of messaging which singled out priority populations as 'vulnerable'. It was challenging to convey messaging in a non-threatening way and avoid contributing to COVID-19 and vaccination fatigue given the overwhelming dominance of COVID-19 messaging. The use of technical language at times limited accessibility of information to parts of the population.

Changes to communications

A key barrier to development of communications was the constantly evolving policy considerations and decision-making which changed the focus across the winter period. The winter-focused campaigns started prior to July 2022, but then had to incorporate messaging relating to the Winter Surge Package measures after they were announced. Communications stakeholders said this made it difficult to coordinate messaging from a system-wide perspective and ultimately caused significant confusion for the public. This was compounded by the wide range of measures included in the Winter Surge Package which sometimes required quite distinct messaging.

An example was the messaging around the flu and COVID-19 vaccinations. A conscious choice had been made at the beginning of winter to separate the messaging around vaccinations in to respond to different population sentiments. However, the Winter Surge Package then sought to align the roll-out of the flu and COVID-19 vaccinations. This changed the communications messaging and caused confusion around eligibility.

Delays

The communications approach was largely reactive, rather than proactive, due to the absence of a widely understood comprehensive, all-of-Government communications strategy. We understand that there was an all-of-Government communications strategy which was written by Manatū Hauora and endorsed by responding agencies. However, throughout the review, very few stakeholders from Manatū Hauora, DPMC Comms or Te Whatu Ora appeared to be aware of or made reference to this strategy. Wider knowledge and familiarity with this strategy could have provided both flexibility and tolerance for communications that were focused yet tailored to respond to existing and emerging needs.



Changing messages contributed to a delay in communications being available to a range of populations. Communications were provided in accessible formats through the Department of Internal Affairs and Ministry of Social Development's Accessible Formats Team. These materials take time to develop and there was often at least a two-week lag between general communications being available and translations or accessible formats. This particularly affected the disabled community who rely on large print, digital, audio or braille formats. We heard that more consideration needed to be given to targeted communications designed specifically for young disabled people.

Māori and Pacific communities

Stakeholders, including those representing Māori and iwi perspectives expressed concerns that the development of communications lacked sufficient consultation and input from Māori and Pacific communities, resulting in messaging not being fit for purpose. For example, many members of priority populations did not know they were eligible for antivirals after the age criteria was extended. The National Iwi Chairs Forum provided Manatū Hauora with strong feedback on this lack of engagement and targeted communications at the time. We heard that some agencies attempted to “translate” existing communications collateral to engage with Māori audiences which did not work.

As a response, several Māori and iwi groups developed and financially invested in their own innovative communications plans – such as creating and disseminating booklets for marae on how to safely maintain a marae.

In contrast some stakeholders had mixed feedback on the effectiveness of by Māori, for Māori campaigns such as Karawhiua. Some stakeholders suggested that this approach only reached a subset of the intended audience while other Māori communities are more likely to engage with generic messaging.

3.7.1.2 Lessons learned

We identified elements that would contribute to the success of future winter campaigns. This includes positive practices that were adopted and should continue, as well as areas for improvement.

- Communications should be framed generically to apply to a range of health measures. The focus should remain on preparedness and preventative activities that the public can do to keep themselves well, such as encouraging facemask-wearing.
- Communications should provide rationale for the desired behavioural or lifestyle changes to support public uptake and understanding of messaging.
- Communications should share up-to-date data, with a focus on equity, such as influenza rates to provide transparency and support communities to understand risks (if data can be made available on a timely basis).
- Campaign planning should be informed as far as possible by up-to-date data around public perceptions (such as perceptions around COVID-19, influenza and vaccinations).



- Campaigns should have dedicated project management to oversee alignment of communications, channels and timeframes. Teams should continue to be resourced with experienced and qualified members that provide creative, in-house capability.
- Campaigns need to be planned with sufficient lead in time to begin communications and allow for messaging to circulate.
- Targeted communications for priority communities need to be available in accessible formats at the same time as general messaging. This requires messaging to be developed sufficiently in advance to give time for translations.
- Sufficient resourcing and capacity need to be made available to support a comprehensive communications campaign.
 - The value of health service availability and provision is optimised when supported by a strong communications approach.
 - There is a need for greater consistency and clarity of sign-off processes for targeted communications to Māori and Pacific communities, including consultation with groups, such as the Iwi Communications Collective and the National Iwi Chairs Forum.
 - There is an opportunity to invest in, develop and formalise a Communications Strategy for priority populations with leadership from regional voices. This could focus specifically on Māori and other priority communities such as disabled people and Pacific peoples. This would allow Manatū Hauora, Te Aka Whai Ora and Te Whatu Ora to coordinate communication efforts with local groups, strengthening existing successful regional relationships and channels.

3.8 Therapeutics / antivirals roll-out

Oral COVID-19 antiviral medications (Paxlovid and Molnupiravir) had been available to eligible people since 4 April 2022. Antivirals were seen as a key intervention to prevent the more severe impacts of COVID-19 and prevent hospitalisations. It was estimated that for every 10 people over 60 who received antivirals there would be one less hospitalisation. It was also believed that providing better and easier access to antivirals would reduce some pressure on primary care.

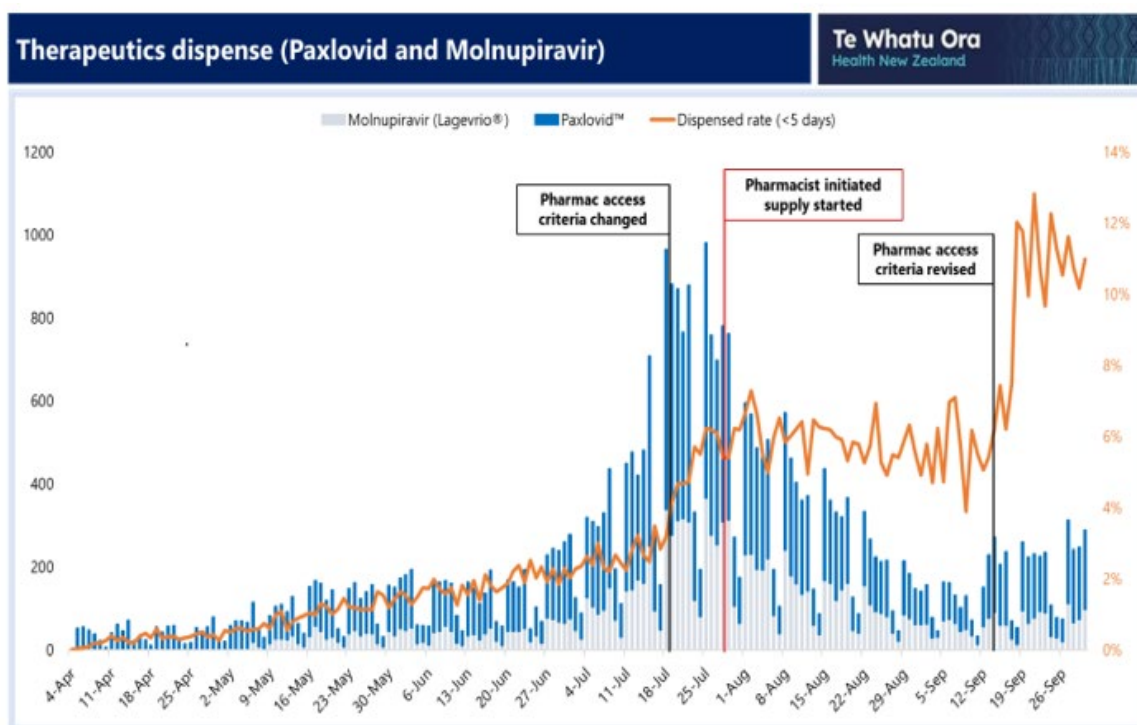
In mid-July Pharmac announced updated access criteria, expanding access to approximately 10% of the population and lowering the age of eligibility for Māori and Pacific people aged over 50. From 28 July 2022, pharmacists were allowed to dispense antivirals to eligible patients without a prescription. At this time, it was also announced that back-pocket prescriptions could be provided to eligible people to be filled if they developed COVID-19.

On 14 September 2022, Pharmac expanded the access criteria again, making approximately 20% of the population eligible for antivirals.

3.8.1.1 Evidence – uptake of antivirals

Data shows that expanding the access criteria in July and September had the most significant impact on the dispensed rate of antivirals.

Figure 6: Volume of antivirals dispensed and dispensed rate



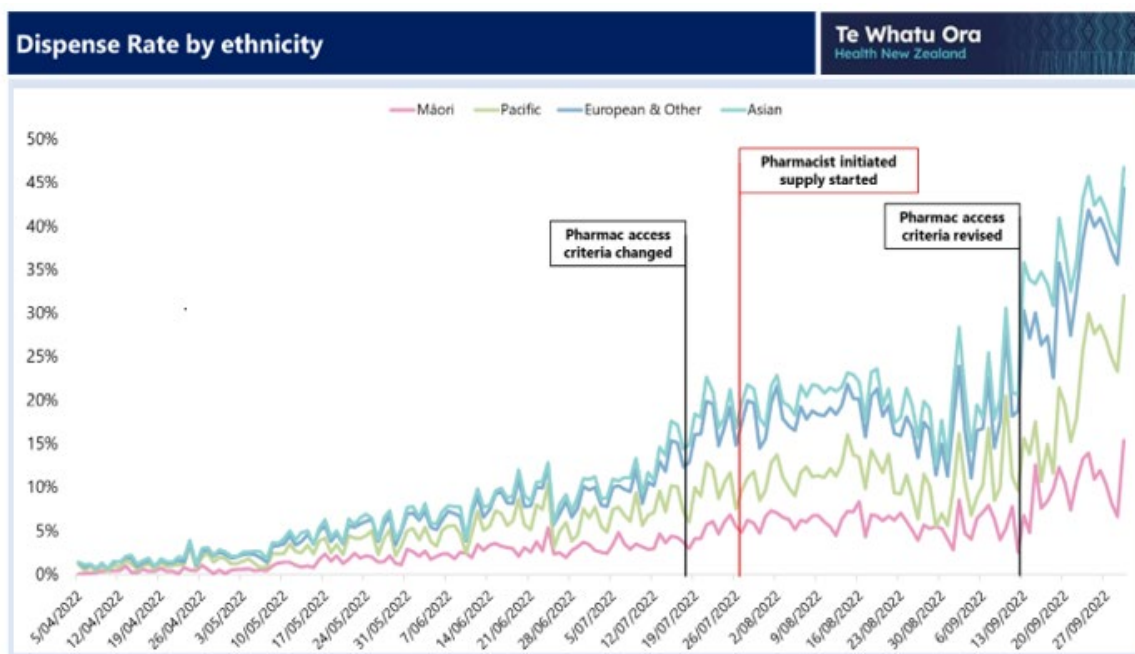
In contrast, the introduction of pharmacist-initiated direct supply appears to have had limited impact on the volume of antivirals dispensed, with numbers remaining relatively static in the August to mid-September period.

The data available does not provide any clear insights into the impact of back-pocket prescriptions.

Data also shows that the success of the interventions varied by ethnicity. The supply of antivirals to Māori did not increase at the same rate as for other populations during the winter period, although similar trends can be seen with greater increases in dispensed antivirals following the expansion of access criteria.

The greatest increase in volume of antivirals dispensed was for Pacific people following the September expansion of access criteria. The use of pharmacies had the greatest impact for Asian and European people followed by Pacific peoples.

Figure 7: Volume of antivirals dispensed by ethnicity



3.8.1.2 Evidence – effectiveness of measure

We were not supplied with any data to indicate whether the increased uptake of antivirals was effective in reducing the severity of COVID-19 outcomes or hospitalisations. However, general research into the effects of these antivirals suggest they are effective in reducing hospitalisations and deaths from COVID-19.

3.8.1.3 What we heard

The use of antivirals is a key measure to limit the impact of COVID-19. Many stakeholders acknowledged this and welcomed the measures that were implemented. Stakeholders from the National Public Health Service, the Public Health Operational Group and the National Immunisation Programme in particular were keen to see the distribution of and access to antivirals further increased. Reducing the unintended consequences of barriers in the Winter Surge Package would in their view significantly increase access and uptake.

Access criteria

Access criteria for antivirals is set by Pharmac using scientific analysis and data. Frustrations were raised by some stakeholders about this process and the resulting outcomes. Some stakeholders voiced concerns that the response and delay in expanding criteria was not aligned with clinical advice. It was felt that antivirals should have been made more widely available earlier and that this would reduce pressures on primary care and hospitals.



However, across the winter period officials were able to build stronger relationships with Pharmac which enabled decisions to be made in a proactive and holistic way.⁸

Availability of supply

Stakeholders told us that information about volumes and timings of supply were not supplied to officials and stakeholders until the last minute. From an operational perspective this created difficulties with creating appropriate and efficient processes to ensure supply across the country. This caused issues with trying to coordinate supply across primary care. Some stakeholders commented that some primary care providers were reluctant to prescribe antivirals given the known frustrations with accessing supplies.

Supply via pharmacies

It was hoped that the shift to having antivirals supplied by pharmacies would make a large difference to those in need. This was intended to increase equity of access through the additional option of a primary care interface (pharmacies) that may be seen as trusted health providers. This took into consideration the fact that many vulnerable or remote communities had better access to pharmacy services than GP or hospital services.

Stakeholders felt that established relationships between Te Whatu Ora and pharmacies enabled rapid progress to be made in the roll-out through pharmacies. Over 1,000 pharmacies were trained in the COVID-19 IT system to enable them to supply antivirals. However, despite the number of pharmacies trained, uptake was comparatively low with only 400 pharmacies actually supplying antivirals.⁹ Overall uptake of antivirals through pharmacy prescriptions accounted for only 5% of the total volume dispensed. Many stakeholders viewed this as a missed opportunity to increase the access in rural areas and to priority communities.

Stakeholders felt that one thing that may have contributed to the lack of uptake was that a communications plan was not fully developed. There were gaps in key messages, different content on various websites and engagement did not include all stakeholders. There were no targeted communications for priority populations. Priority populations were also not involved in the planning or roll-out, potentially missing the opportunity for a more targeted, equity-based approach.

We heard that there was also pushback against the initiative from GPs, who felt it impacted their clinical and ethical responsibilities towards their patients. Officials received feedback informally that it would impact on the doctor / patient relationship, and appropriate information / follow-up would not be managed appropriately if antivirals were administered through pharmacies.

⁸ Note that it was not in scope for the Review Team to speak to any representatives from Pharmac in order to understand their perspectives.

⁹ Most of these pharmacies were in urban areas.



Prescriptions via Nurse Practitioners

The reclassification of antivirals meant that they could be prescribed by nurse practitioners. This provided the opportunity for engagement with Hauora providers and Pacific providers to support reach to priority communities. However, stakeholders felt this was not initially understood by operational teams and engagement with these providers did not occur until mid-to-late September. Many stakeholders saw this as a missed opportunity.

Back-pocket prescriptions

Advance prescriptions for antivirals were viewed by stakeholders as less successful than the other measures. We heard that there was a reluctance from GPs to use this mechanism. The announcement about back-pocket prescriptions was made prior to GPs being advised of the changes and this caused some negative feedback. In addition, having two new pathways for antivirals created some confusion and negative feedback from primary care.

Different types of antivirals

A stakeholder told us that there is an inability to report on the difference between Paxlovid and Molnupiravir dispensation rates which may give rise to equity issues. The two antivirals have different effectiveness and have been marketed differently to priority populations. The stakeholder suggested that monitoring prescribing patterns and outcomes for priority populations will be important in future equity analysis.

3.8.1.4 Lessons learned

We heard that Australia, Canada and the United Kingdom were particularly interested in learning from the approach taken in Aotearoa New Zealand to reclassify antivirals to be dispensed via pharmacies, nurse practitioners and back-pocket prescriptions. It was generally agreed that this move created opportunities to increase access to priority populations – but implementation hindered the potential positive impacts.

There is scope in future to improve these methods of dispensing antivirals. This would need to be supported by adequate engagement with GPs, pharmacies and Hauora providers. Communications between these health professionals is important to ensure continuity of care in the community. While the IT system provides a mechanism to do this, pharmacies and GPs should work together to establish a framework for collaboration for the future. Engagement with community providers, iwi and Pacific providers, disabled people and tāngata whaikaha Māori is key to ensuring access barriers are removed as intended and communications are fit-for-purpose.

There is a need to track cases, unreported cases and antiviral prescription with real-time hospital admissions and / or deaths to identify if priority populations are being served and respond accordingly to those whose needs are not being met.

4.0 KEY FINDINGS – GENERAL THEMES

4.1 Planning

4.1.1.1 What we heard

Despite the obvious success in being able to implement a diverse and comprehensive package of measures within a short timeframe and a challenging operating environment, some stakeholders thought that lessons could be learnt for the future to improve planning. Many of the comments in this regard focused on a “blue sky” approach where officials would not be constrained by timing of decisions being made and advice commissioned.

Objectives of the Winter Surge Package

The objectives of the Winter Surge Package are set out in the Health Report to Minister Verrall dated 8 July (HR20221186). This included the overarching question “what additional public health measures could be introduced to reduce the impact of COVID-19 and other seasonal illnesses through winter 2022 on the health system (primary care and hospitals), society and the economy?”.

Despite this, many stakeholders felt that the Winter Surge Package lacked a clear objective. This perception may be a result of the objective not being clearly communicated throughout the organisations involved, or a lack of understanding by the relevant stakeholders. We note that the objective as described above is extremely broad and is unlikely to give sufficient direction at an implementation level. This broad objective aligns with the majority of the measures which appear to be aimed at population wide initiatives, with some more targeted measures.

Many stakeholders felt that focussing on more specific objectives such as hospitalisation rates may have lead to a different approach to the measures. All stakeholders agreed that a key focus during the period was on reducing hospitalisation rates, but this was one of a broad range of objectives.

For example, some stakeholders considered that not enough emphasis was given to measures designed to support GPs to meet capacity challenges. Overflow from General Practices is often a significant contributor to patients presenting at a hospital – and placing pressures on hospitals. The Winter Surge Package included exploration of options for diverting health queries and reducing low value work in primary care but this does not appear to be a large emphasis in the measures. We were unable to determine what actions occurred in these areas.

Another example provided by a stakeholder was considering extending antiviral eligibility for disabled people and their carers. Whaikaha has suggested that disabled people are more likely to have a severe case of COVID-19 because of underlying medical conditions,



congregate living settings or systemic health and social inequalities¹⁰. If this is true, a targeted measure for this group would be likely to have been effective in reducing hospitalisation rates.

Timing

There was a strong view presented by stakeholders with public health expertise that policy solutions should have been put in place to respond to the winter conditions sooner. Modelling clearly pointed to Aotearoa New Zealand experiencing a wave of Omicron during the winter months and this was supported by evidence from overseas, particularly Australia.

These stakeholders felt that reactive surge responses were less effective than measures which could be put in place from the beginning of winter which would allow for better planning or public messaging to support uptake.

For example, one stakeholder expressed that the free flu vaccines for 3-to-12-year-olds came too late to achieve high-levels of immunity entering winter and so were less effective. In this case, the data shows increased flu vaccine uptake for children after the introduction of the package. This would seem to indicate achievement of the aim of the measure. However, given that vaccines are a preventative measure having strong vaccine uptake earlier in winter would have had more impact.

Most stakeholders felt that an annual winter plan (which anticipates surge conditions) was preferable to a reactive surge response.

Health and disability system preparedness

There was a perception amongst many operational stakeholders that the Winter Surge Package implementation was hindered by problem with the sufficiency of BAU winter planning. Prior to the health and disability system transformation, DHBs were responsible for their own BAU winter surge planning. This planning is typically shaped around preparedness for increased hospitalisation rates and staff shortages (due to winter illness).

There was a perception from some stakeholders that this annual planning is not sufficient, even outside of a pandemic. Note we have not been able to assess the sufficiency of DHB planning in this review. In contrast, some stakeholders from Te Whatu Ora felt that Manatū Hauora lacked the necessary expertise and understanding of the local conditions to support winter planning. The impact was that some DHBs pushed back against Manatū Hauora's attempt to involve themselves in the winter surge response.

Implementation

Many operational stakeholders expressed a view that there was not adequate time allowed to consider operational viewpoints when making decisions. This is supported by a key briefing on the Winter Surge Package (HR20221186) which asks Minister Verrall to make decisions on the measures to be introduced without providing any advice on implementation challenges

¹⁰ Note, as previously identified there is a lack of data specifically relating to disabled peoples experiences of COVID-19 including hospital and mortality rates so we cannot provide evidence to support this hypothesis.



or risks. This may have been included in later advice (which was not made available), however, stakeholders felt this should have been a consideration at the initial decision point.

In particular, operational stakeholders felt that there was no time to consider health and disability system readiness for the measures. While many measures were already planned or being implemented, we heard the escalation of measures under the Winter Surge Package created significant stress in the system. For example, some measures were introduced before operational teams or stakeholders (such as GPs or pharmacies) were ready to respond. This hindered cooperation with these stakeholders and exposed them to negative public feedback when public messages did not match the operational realities.

Despite this perception, we understand that all the measures were able to be implemented. We have commented more specifically on implementation considerations relevant to each measure under the specific measures.

4.1.1.2 Recommendations

In 2023 there is an opportunity to create a robust, timely Winter Surge Plan. This plan should:

- Have clear objectives which are understood and shared across the health and disability system. In future this will allow prioritisation of measures.
- Be supported by modelling and international evidence on what conditions Aotearoa New Zealand can expect in Winter 2023. This should include consideration of illnesses beyond COVID-19 and other respiratory illness¹¹ (for example, national immunisation data shows that measles immunisation coverage at six months of age has fallen from around 80% in early 2020 to 67% in June 2022.¹² Vaccination rates for Māori are only 45%. This creates a risk of a significant measles outbreak in winter 2023).
- Consider challenges and opportunities across the spectrum of healthcare services including primary, community and secondary care. This will provide a broader range of levers to impact key metrics such as hospitalisations (although this should not be the only focus).
- Include health and disability system readiness for implementation as a key policy decision-making metric to ensure that measures can be readily implemented. This should be supported by data and information about the level of health and disability system readiness at any time and involve input from a range of health system workforce representatives to understand any practical implications.

Some stakeholders suggested that there should be an annual COVID-19 seasonal response plan which takes into account different seasonal pressures and public health considerations.

¹¹ We note that the Te Whatu Ora Outbreak Response Team has already shifted to a model which plans for COVID-19 alongside other possible future outbreaks.

¹² National Immunisation Data accessed at <https://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data>.



Long-term this may be worth further thinking, however, in the immediate term we suggest the focus should be maintained on winter readiness as the most immediate priority.

There is a role for Manatū Hauora to coordinate planning across the health and disability system to ensure challenges are understood, and the range of levers available to respond to surges are coordinated.

Stakeholders also suggested that lessons could be learned from other areas that adopt BAU approaches to emergency or contingency planning, such as civil defence planning. We recommend that Manatū Hauora consider what lessons from other sectors could be applied to winter planning.

4.2 Coordination across agencies

4.2.1.1 What we heard

The introduction of the Winter Package was complicated by the health and disability system transformation taking place. Throughout the winter period, the structure of the health and disability system agencies changed, meaning a significant number of key stakeholders changed roles and responsibilities. This hindered planning and implementation of the measures – in particular, some stakeholders noted this occasionally led to certain initiatives lacking a lead owner.

While personnel with reallocated roles and responsibilities in central health agencies were supported through the transition, the change period was challenging. For instance, ways of working, processes and relationships were being re-established at the same time as the winter measures were being implemented. This impacted on efficiency and effectiveness of coordinated activity and was further compounded by the time-constrained environment.

Many stakeholders felt that there was greater scope for leadership from Manatū Hauora to coordinate efforts across the health and disability sector. For example, the roll-out of therapeutics required input and collaboration between GPs and pharmacists. There was a high degree of public frustration around access to therapeutics – as public announcements told people they were available, but they were not widely accessible. Some stakeholders felt there was a need for greater support from Manatū Hauora to design and support implementation of processes to get back-pocket prescriptions.

4.2.1.2 Recommendations

There is an opportunity to think strategically about the roles of Manatū Hauora, Te Whatu Ora and Te Aka Whai Ora in helping to coordinate and lead initiatives across the health system. Several governance groups, including representation from these three agencies, have already been established to do this, and were meeting regularly throughout the response.

Many stakeholders felt that Manatū Hauora should be providing further leadership and coordination across the health system including for winter planning. However, this will require significant support and coordination with other agencies to ensure appropriate expertise and insights are incorporated from across the health system.

4.3 Data and modelling

Extensive data analysis and modelling is undertaken on an ongoing basis in relation to COVID-19 cases, hospitalisation rates and mortality risks.

Analysis of available data shows a shift in who was most affected and at risk of COVID-19 during various periods.

- 15 – 24-year-olds showed an increase in cases post 17 April.
- 45 – 64-year-olds were more affected in the July to August period.
- Older groups were more affected over winter when the proportion of people over 60 with COVID-19 in hospital reached 70%.

4.3.1.1 What we heard

Time pressures

One of the key challenges was the pace at which data and analytics were required for policy decision-making. This impacted on the ability of data and insights teams to provide a holistic perspective of the situation, risks of transmission and projected cases / hospitalisations. Data was collected in a timely basis and analysed as quickly as possible, but this could not meet the 48 – 72-hour timeframes of policy decisions being made. A few stakeholders felt a better balance needed to be achieved between providing a rapid response and being able to gather and analyse complex insights.

Modelling

Some Manatū Hauora stakeholders felt there was an overreliance on modelling in decision-making both during winter and during the COVID-19 response overall. Although modelling is a useful tool which has a place in policy-making – it was felt that too much stock is put in the modelling. In an environment where COVID-19 will circulate in the community, there was a need to consider the broader health environment rather than specifically focusing on COVID-19 rates. In contrast many stakeholders felt that the modelling was clear leading into winter and more weight should have been given to preparing appropriately for the response. By contrast other stakeholders noted that decision makers were aware of the need to avoid this scenario and careful attention was given to ensure all evidence was balanced in designing interventions.

We have not been able to assess whether there was an overreliance on modelling. We note that very little surveillance data was provided to support HR20221186 which conveyed the main policy decisions. However, this information may have already been known to the Minister from other reporting.

We also note that a review of the modelling has found that models have accurately predicted the rates of COVID-19 cases, hospitalisations and deaths.



4.3.1.2 Lessons learned / Recommendations

It is recommended that a comprehensive review of available data is completed to identify where there are gaps in available data and reporting and to ensure all population groups are sufficiently covered.

It is recommended that disaggregated data relating to viruses and healthcare system capacity should be captured and reported across a 12-month period to capture seasonal variations, peaks and troughs with COVID-19 waves and other environmental factors.

It is recommended that ongoing monitoring be built into the planning phase for new initiatives to allow for effective evaluation of measures.

4.4 Other challenges in the winter period

Although some of the comments made in relation to other challenges in winter were outside our explicit scope, we have included a short commentary as these matters were raised by numerous stakeholders and had an effect on matters within our scope.

4.4.1.1 What we heard

Several operational stakeholders felt a significant burden was placed on Manatū Hauora to provide public health advice and guidance to other agencies about what measures they should be putting in place. While some of these initiatives relied on specialised public health advice, a number of other issues (such as business continuity planning for staff shortages) arguably did not require health input. This created significant stresses for Ministry staff who reported they already felt busy and under-resourced.

There were mixed views from stakeholders about Manatū Hauora providing this advice in the longer-term. Many stakeholders felt that other agencies needed to take more responsibility for continuity planning – given the levels of information available about infection prevention control, it was felt other agencies have sufficient tools to develop their own initiatives (within reason). However, other stakeholders felt that it was important that Manatū Hauora continues to provide high levels of advice across Government to support initiatives and ensure they continue to be informed by public health advice.

There was a universal concern amongst stakeholders about the future impact of Manatū Hauora needing to provide advice across Government. In particular, there was a concern that this burden would increase in future due to functions designed to respond to COVID-19 being stood down across Government, meaning they may not have the capacity or capability internally to respond to COVID-19 considerations.

4.4.1.2 Recommendations

Further consideration should be given to what resources will be required to support winter planning and response across Government and how this will be managed, such as timely planning and commissioning by Ministers based on real-time data.

There is an opportunity for public health to take a more strategic approach to providing public health guidance/health-emergency response planning, to reduce the number of ad hoc inquiries.

5.0 KEY FINDINGS – EQUITY

The Ministry of Health’s definition of equity is:

“In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.”¹³

Throughout the pandemic, the impact of COVID-19 has been felt disproportionately by priority groups including Māori, Pacific peoples, disabled people and elderly people. Concerns have been raised through a number of channels about the adequacy of the government’s response for these priority groups.

The Winter Surge Package is only one policy package in the wider COVID-19 context and was not designed or expected to address underlying systemic equity issues.

The approach to the Winter Surge Package was described by the Ministry as an ‘equity-first’ approach “which involves ensuring disproportionate risks to certain individuals are considered as part of developing our COVID-19 response strategies.” This included working with affected priority communities. This ‘equity first’ approach was explicitly outlined in key documents and described to us by Manatū Hauora stakeholders.

The Appendix to HR20221186 notes some considerations for priority populations which were to be investigated or actioned. The table below is not exhaustive but provides some examples of these actions.

Table 4: Measures for priority populations

Priority population	Measures
People over 50	Access to COVID-19 booster
Children	<ul style="list-style-type: none"> • Free flu vaccines for 3-to-12-year-olds • Distribution of facemasks • Funding for schools to support use of facemasks and ventilation in schools
Clinically vulnerable and high-risk individuals	Distribution of P2 / N95 masks
Disabled people	Review barriers to accessing RATs
Rural communities and other communities without access to GPs	Making antivirals available through pharmacies

¹³ <https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity>



The ongoing consideration of equity issues as part of the broader COVID-19 work programme and existing relationships with communities enabled these measures to be successfully stood up in a short period of time.

These measures demonstrate that the Winter Surge Package did include different approaches and resources for different communities based on their vulnerability to COVID-19 or to experiencing negative health outcomes.

In determining whether these initiatives were effective in achieving equitable outcomes, we relied on the experience shared with us by people who work directly with or are part of identified priority communities.

We note that the comments provided by stakeholders were often outside the scope of this review – i.e., applied to the health system response to COVID-19 generally as well as to the response over the winter period. We have attempted to balance reflecting on how people experienced the overall health system response to COVID-19 with how the specific Winter Surge Package measures impacted on equity. A summary of additional comments has been included at Appendix 4.

5.1.1.1 What we heard

We heard from key stakeholders that the Winter Surge Package could have done more to achieve equitable outcomes.

Definitions of equity

We heard from stakeholders who work with priority communities that there appear to be different views across central health agencies about what equity means and what it requires. Stakeholders noted that “having a common understanding of equity is an essential foundation for coordinated and collaborative effort to achieve equity in health and wellness”¹⁴.

An example given by several stakeholders of where equity could be better understood was in a ‘whānau-centred approach’. A ‘whānau-centred approach’ was a term used in reports and documents – and provided as an approach that centres on equity for Māori populations. There was not an integrated and coordinated understanding of what a whānau-centred approach should look like across the range of services and systems whānau have to navigate. This approach did not reflect the realities of people in priority communities and the whānau who it claimed to serve.

An example of how this presented during the winter period was in vaccination policies. Different eligibility ages for vaccinations (or free vaccinations) meant that if whānau presented as a group to be vaccinated only some whānau members would be eligible. This included children under 3 who were required to be vaccinated at the GP, so could not get vaccinated with their whānau at marae or other community centres. To turn away whānau members who might not enter a health setting again does not have whānau at the centre of the approach.

¹⁴ Achieving equity work programme- [John Whaanga, Deputy Director-General Māori Health](https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity) and Dale Bramley, Waitematā DHB CE.
<https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity>



Many providers, conscious of the requirement to meet whānau needs and to capitalise on the opportunity to vaccinate people (which may not have presented itself again), chose to vaccinate all whānau members despite it being against the rules at that time.

Equity in implementation

Stakeholders told us there was a disconnect when it came to national policy level decision-making versus the reality of what was happening on the ground. Decisions were made at the top level, with the expectation that regions would be able to put measures into action. This created inefficiencies and plans which needed to be reworked to try and meet demands. Decisions were not always explained, nor context given to operational teams.

We understand that policy officials tried to stay in touch with operations once they had set the direction, but the reality of trying to keep on top of implementation was often met with competing workloads and priorities and eventually oversight was lost.

We understand community and iwi leaders tried to talk to officials about supporting their organisations to work with communities to do research and gather insights and feedback about what actually happened in winter 2022. However, this has not yet garnered official support.

Fast-paced response

Almost all stakeholders told us the package was rushed through at a time when everyone was extremely busy and it was difficult to provide meaningful input on equity considerations. Stakeholders believed that if there had been more time for Manatū Hauora to develop and implement the package there could have been stronger collaboration efforts, better data collected and more input from vulnerable communities and Treaty partners into the package.

These stakeholders felt that the time constraints of the Winter Surge Package often led to shortcuts or an emphasis on approaches that utilised existing systems and structures which do not always reach Māori.

Engagement with communities

We heard from most stakeholders that engagement at central levels with Māori and other vulnerable communities was inadequate. Little outreach was done at the ground level to understand vulnerable communities and their concerns for winter.

It was recognised early when winter illnesses were emerging that disabled people experience barriers to accessing public health measures and organisations representing disabled people were requesting due planning and support. However, the lived experience of disabled people was not adequately sought during development of the Winter Surge Package. This was attributed, at least in part, to the recent establishment of Whaikaha on 1 July 2022 and the challenge for health officials to know who to connect with in this new Ministry.

Most stakeholders told us that during winter 2022 equitable outcomes were generally best supported when there were partnerships in place that allowed for proper collaboration. Many suggested that these partnerships need to be maintained year-round, across all levels of Government, iwi, hapū, health providers, communities and advocacy groups to allow for complete transparency and involvement at all stages, rather than only being consulted during crises.

However, stakeholders identified some positive initiatives to build upon for the future.



A widely cited example of a successful equity initiative was the Māori Providers Distribution Channel (the Distribution Channel). The Distribution Channel was reviewed by *Allen + Clarke* in November 2022 and stakeholders explicitly referred to the findings from that review.

When establishing the Distribution Channel, the Equity Team at Manatū Hauora created a prototype distribution model for RATs, facemasks and other health supplies which was tested and refined based on feedback from Māori providers. This demonstrated a working partnership that included Māori in the process from the initial planning rather than reactively seeking input after decisions had been made.

The review, which was based on interviews with Māori and Pacific providers and representatives from Manatū Hauora found that “the [Distribution Channel] provides an excellent example for public health practitioners wanting to improve Māori health outcomes and ensure indigenous engagement, leadership and substantive authority in the distribution of health resources.”

During the winter period we heard that the Distribution Channel was able to respond quickly and efficiently to new demands – including increased supply of facemasks and RATs to priority communities.

5.1.1.2 Lessons Learned

We note that most of the lessons we have identified in relation to equity apply to the health system as a whole. As would be expected, these system-level issues had a significant impact on the experience of priority populations during winter.

Consideration of further targeted measures

Many stakeholders raised further targeted measures that they felt could have been put in place to address the needs of priority populations. It would not be appropriate for the Review Team to recommend these measures be adopted without obtaining specific public health advice, however, it is worth noting there appeared to be demand for further tailored measures and approaches to achieving positive health outcomes for vulnerable communities.

Tools to consider equity

Stakeholders identified a variety of factors that are needed across the health system to support more robust consideration of equity. These factors included investment in capacity-building, education and internal capability to ensure equity is well understood and not simply a tick-box exercise.

Partnering with communities

Where the health system enabled communities to take a lead role and allowed for partnership with Māori and Pacific providers there were better outcomes in terms of higher vaccination rates. This required functional alignment with Māori and Pacific providers, working alongside and enabling them to take ownership of the service delivery and share knowledge. To achieve equitable outcomes, Government needs to partner with the appropriate people and recognise and relinquish control over who is best to serve vulnerable populations.



There needs to be a concentrated effort to strengthen community networks and collaborate on insights that incorporate mātauranga Māori and other cultural perspectives, and lived experiences of vulnerable groups when developing solutions. These insights should inform policy decisions, and not just be drawn upon on at the service delivery stage. Māori, Pacific and disability providers need support from a national level to prepare their workforces to respond. They require support to ensure that the services can be delivered in culturally appropriate ways and that appropriate training is given if these providers are to be relied upon in the future.

A partnership approach requires relationships to be maintained across the whole year to build cultural and clinical services that support whānau and vulnerable communities.

Engagement with disabled people

There is an opportunity for Whaikaha to be at the forefront of leading early engagement with disabled people as part of health system responses by harnessing their networks among disabled communities. Whaikaha has suggested that Manatū Hauora and Te Whatu Ora need to build stronger relationships with disabled people's organisations and the disability sector. This includes genuinely listening to and understanding the lived experience of disabled people, such as their common activities and challenges related to accessing medicines and health services. This should inform the approach taken to ensuring equity of access and outcomes from any changes to, or introduction of new, public health measures to target winter illness.

There should also be consideration of compliance with responsibilities under the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and other strategies and approaches that guide the Government's approach to disability issues. This includes the *Enabling Good Lives* approach – which envisions choice and control for disabled people in their lives and the supports they receive, the UNCRPD principle – “nothing about us without us”, the *New Zealand Disability Strategy* and the *Disability Action Plan 2019-2023*.

There is a need for purposeful data collection and appropriate data sharing that is focused on the aspirations, needs and outcomes of disabled people, to understand how to design measures that will effectively support them and guide decision-making.

6.0 KEY FINDINGS – TREATY PARTNERSHIP

6.1.1.1 What we heard

Engagement

A number of stakeholders raised the need for a wider and more strategic approach to engaging Māori. We heard that Māori need to be recognised as a treaty partner, not just an important stakeholder. Successful engagement requires more than just speaking to a limited number of Māori across Government and thinking this meets obligations under Te Tiriti o Waitangi.

We heard that addressing the needs of Māori means taking a holistic approach to helping overcome significant barriers such as cost, barrier to services, poor service experiences, cultural barriers and poor health literacy. It was often the initiatives of iwi and Māori that allowed whānau who would otherwise remain isolated and absent from health services to be connected.

All year round, but particularly in winter, there was a large cohort of Māori who only entered the health and disability system through emergency services or when they needed antibiotics. There were consistently lower rates of vaccination in Māori communities and the system did not support whānau who were not presenting to a health setting to be identified and receive the care they were eligible for.

Many smaller iwi struggled to respond to the needs of their communities as they had limited capability and infrastructure. It often fell to larger iwi with more resources to support them and their vulnerable communities, rather than being supported by central Government. At a local level, this was done by iwi using data systems through connections they had at PHOs, heat mapping, identifying areas to build up more communications or access and building overall awareness.

6.1.1.2 Lessons learned

The articles of Te Tiriti place a mandatory obligation on the Crown to protect and promote Māori health.

- *Kāwanatanga* ensures equitable Māori participation and or leadership in setting priorities, resourcing, implementing and evaluating policy.
- *Rangatiratanga* allows for Māori values to influence and hold authority in the policy process.
- *Ōritetanga* enables Māori to exercise their citizenship rights as Māori in policy.

In practice, this means that Māori need to be considered equal and lead partners in policy processes and have mechanisms in place to support Māori leadership in decision-making. At all levels of planning officials should actively seek input from those with lived experience and speak directly to Māori to ensure policies and their implementation supports a whānau-centred



design. This approach does not limit the benefits to only Māori, as getting things right for Māori benefits the total population.

Iwi need to have tino rangatiratanga over all data that concerns Māori. It is of high importance to iwi to know who is vaccinated, so that better evaluations, reviews and implementation plans can be applied for the benefit of their people.

7.0 PRIORITY RECOMMENDATIONS

The following section provides a brief summary of recommendations arising from the review. More specific recommendations relevant to each specific measure can be found in the relevant sections of the report.

Measures which should be adopted or emphasised in 2023

Given the data available, we were not able to draw many conclusions on the effectiveness of particular measures – however, we have summarised our findings on particular measures below:

Table 5: Recommendations for measures

Measure	Recommendation
COVID-19 vaccinations	COVID-19 vaccinations remain a key tool to prevent the spread of the virus. However, public perception of the need for boosters remains a significant barrier to uptake. Clear information and eligibility criteria should be considered for 2023 along with messaging on the continued importance of the vaccine.
Supply and distribution of facemasks	Use of facemasks will likely play a significant role in future winter preparedness. It is anticipated that general supply of facemasks in the community will be high, so further investment should prioritise efforts to distribute to vulnerable populations and those most at risk.
Supply of RATs	Supply of RATs to the public will likely continue to be a key measure to monitor and manage COVID-19 in the community. Further consideration needs to be given to how RATs will be made available to the public (particularly to priority communities) with the disestablishment of storage and distribution centres.
Antiviral roll-out	Eligibility for antivirals for 2023 should be considered early to allow for maximum use across the population. Further investment and planning should be dedicated to supporting antiviral roll-out via GPs, pharmacies and nurse practitioners. This should extend to data collection and analysis of population access rates and impact on hospitalisations.
Aligning flu and COVID-19 vaccinations	Further research and consideration should be given to the benefits and risks of aligning flu and COVID-19 vaccination campaigns. There are risks that this may decrease uptake of the flu vaccine, although this was not supported by data from 2022 (for over 65s).
Extra funding and supplies for schools to facilitate use of facemasks and ventilation	Our findings on the efficacy of this measure were inconclusive. Further research and coordination with MoE is required.



The communications campaign should be a priority for 2023

In 2023 winter communications campaign will one of the crucial levers that Government has to respond to winter surges. Our recommendations on best-practice communications are outlined below.

- Communications should be framed generically to apply to a range of health measures. The focus should remain on preparedness and preventative activities that the public can do to keep themselves well, such as encouraging facemask-wearing.
- Communications should provide rationale for the desired behavioural or lifestyle changes to support public uptake and understanding of messaging.
- Communications should share up-to-date data such as influenza rates to provide transparency and support people to understand risks.
- Campaign planning should be informed as far as possible by up-to-date data on public perceptions (such as perceptions of COVID-19, influenza and vaccinations).
- Campaigns should have dedicated project management to oversee alignment of communications, channels and timeframes. Teams should continue to be resourced with experienced and qualified members that provide creative, in-house capability.
- Campaigns needs to be planned with sufficient lead in time to begin communications and allow for messaging to circulate. Information such as eligibility criteria and availability of supplies needs to be easily available and understandable.
- Targeted communications for priority communities needs to be available in accessible formats at the same time as general messaging. This requires messaging to be developed sufficiently in advance to give time for translations. Consideration should be given to communications for non-English speaking communities, migrants and refugees, youth, rainbow communities and other groups who may have low health literacy.
- Investment should occur to develop a Māori Communications Strategy with leadership from regional voices. This would allow for coordinated communication efforts with Māori groups, strengthening existing successful regional relationships and channels.

The health and disability system must partner with communities to achieve equitable outcomes

Generally equitable outcomes were best supported when there were partnerships in place that allowed for proper collaboration. These partnerships should be maintained year-round, across all levels of Government, iwi, hapū, health providers, communities and advocacy groups to allow for complete transparency and involvement at all stages, rather than only being consulted during crises.

There needs to be a concentrated effort to strengthen community networks and collaborate on insights and information that informs policy decisions, not just being called on at the service delivery stage. Māori, Pacific and disability providers need support from the national level to prepare their workforces to respond and ensure appropriate training is given if they are to be relied upon in the future.



Māori need to be considered equal and/or lead partners in policy processes

At all levels of planning officials should be actively applying the principles of Te Tiriti and ensuring that policy-making and implementation supports a whānau-centred design. In order to be genuine to Te Tiriti obligations, Government officials need to seek input from those with lived experience and speak directly to Māori. This approach does not limit the benefits to only Māori, as getting things right for Māori benefits the total population.

There is an opportunity for more proactive planning in winter 2023

In 2023 there is an opportunity to create a robust, timely winter plan. This plan should:

- Have clear objectives which are understood and shared across the health and disability system. In future this will allow initiatives to be prioritised (assuming that there may be increased funding constraints in 2023)
- be supported by modelling and international evidence on what conditions Aotearoa New Zealand can expect in Winter 2023. This should include consideration of illnesses beyond COVID-19 and other respiratory illness
- consider challenges and opportunities across the spectrum of healthcare services including primary, community and secondary care. This includes opportunities to further involve GPs, pharmacies and nurse practitioners in future measures such as the distribution of antivirals
- consider how large volumes of RATs and facemasks can be freely distributed to communities without existing distribution and storage facilities (which are being disestablished), assuming public health advice supports their ongoing usage.
- consider ventilation in a broad range of settings and how this can be incorporated into the health system response, as recommended by public health experts
- be completed in sufficient time to allow for implementation and communications programmes to be put in place, for example key decisions need to be made at least two weeks in advance of implementation to allow for communications material to be prepared.

While this planning may put in place measures that will be implemented in response to a winter surge situation, most stakeholders felt that an annual winter plan was preferable to a reactive surge response.

Roles and responsibilities in relation to winter responses need to be clear

All the health agencies have a role to play to prepare for winter – by 2023, these respective roles should be clearly understood by all relevant agencies and stakeholders. Manatū Hauora has a central role to play in coordinating planning and policy responses across the health and disability system to ensure challenges are understood and policy settings respond to operational realities. This will require clear understanding and accountability of various central health agencies to bring the appropriate expertise and leadership to the planning function.



8.0 APPENDICES

8.1 Appendix 1: List of measures

Measure	Actions taken
COVID-19 vaccination programme	<ul style="list-style-type: none"> • Free flu vaccine for 3-12-year-olds and COVID-19 booster available for some populations. • Price uplift for Māori and Pacific tamariki vaccination. • More access points geographically, longer open hours. • Extend availability of mobile vaccinators.
Aligning the flu vaccination roll-out and COVID-19 vaccination programme	<ul style="list-style-type: none"> • Offering flu and COVID-19 vaccinations to eligible populations at the same time.
Supply and distribution of facemasks to clinically vulnerable, high-risk individuals and children	<ul style="list-style-type: none"> • Provide facemasks to the general public, through RAT distribution centres, and to school / kura staff and children. • Provide P2 / N95 masks to clinically vulnerable and high-risk individuals. • Provide medical masks with RATs when people pick them up from testing sites and emphasise from testing sites depending on delivery dates. • Provide medical procedure masks via Māori and Pacific distribution channels and enhance these channels further. P2 / N95 masks available for health and non-health settings. • Work with businesses to promote appropriate masking to help reduce transmission in the workplace.
Extra funding and supplies for schools and early childhood services to facilitate the use of facemasks in schools and support ventilation and winter heating	<ul style="list-style-type: none"> • Support decision-making on masking in school settings, inform discussions with teachers and help lead peer discussions. • Provide guidance on specific, practical measures to improve ventilation, including specific methods to emphasise ventilation systems and methods of ensuring they are fit for purpose. • Tailored communications around eligibility for the Close Contact Exemption Scheme for schools / teachers.
Raising the supply of Rapid Antigen Tests to households	<ul style="list-style-type: none"> • Significantly expand access to RATs through: <ul style="list-style-type: none"> – increasing number of RATs provided at testing and collection sites – removing the requirement to be symptomatic to be able to request a RAT – expanding distribution channels.



Measure	Actions taken
Improve access to therapeutics	<ul style="list-style-type: none"> • Improve access to antivirals, particularly for people at significant risk of poor outcomes from COVID-19 by: <ul style="list-style-type: none"> – enabling direct prescribing of antivirals by registered Pharmacists or Registered nurses based on preconditions – providing “back-pocket prescriptions” or pre-approval for antivirals via GPs for access to antivirals for patients at risk of acute respiratory distress to improve timely use of therapy – proactively messaging priority populations – continuing other measures around antiviral availability / targeting, including reviewing supply, broadening eligibility criteria, reviewing effectiveness, monitoring and measuring access. • Review efficacy and availability of existing therapeutics for vulnerable populations: <ul style="list-style-type: none"> – continue to measure and monitor access to therapeutics for the vulnerable – explore COVID-19 pre-exposure prevention options for high-risk groups.
General public communications (sitting alongside specific communications)	<ul style="list-style-type: none"> • Public communications campaign emphasising keeping well during winter and simple things that people can do as part of everyday life, which would reduce their risk. • Communications explaining airborne transmission, including: <ul style="list-style-type: none"> – basics of how COVID-19 is transmitted – types of situations where risk is greater. • DPMC “Masks Matter” campaign.
Better guidance and advice to employers (to protect workers and businesses)	<ul style="list-style-type: none"> • Guidance on specific, practical measures that businesses, employers and PCBUs responsible for indoor areas can introduce to improve ventilation. • Public Health Agency to work alongside MBIE and WorkSafe to develop a package of communications for businesses on how to keep workers safe from viruses: <ul style="list-style-type: none"> – facemasks – reinforce messages to businesses – ventilation – provide practical guidance on improving ventilation – health and safety policies – provide guidance on working from home policies / guidance, masking in workplace, use of IPC measures, improved sick leave provisions. • Further strengthen communications to promote following basic IPC and helping your employers to do so. Stay home if you are unwell and discuss with your employer.
Improve surveillance and reporting	<ul style="list-style-type: none"> • Triangulating surveillance data to support timing of response to reduce demand. • Increase visibility of local case data to help individuals / households understand local risk levels, including:



Measure	Actions taken
	- publish case results region-by-region to help members of the public make informed decisions regarding viral risk management.



8.2 Appendix 2: List of interviewees

Interviewee	Role	Organisation
Alice Marfell-Jones	Group Manager Policy	Te Aka Whai Ora
Allison Bennett	Manager, Vaccination Portfolio Strategy, Policy & Legislation	Manatū Hauora
Annie Hindle	Policy Manager	Te Aka Whai Ora
Asher Wilson-Goldman	Communications & Engagement Lead National Immunisation Programme	Te Whatu Ora
Astrid Koornneef	Director, Prevention National Immunisation Programme	Te Whatu Ora
Bex Bruno	Programme Manager National Immunisation Programme	Te Whatu Ora
Brian Watson	Manager Strategy, Policy & Legislation	Manatū Hauora
Celeste Gillmer	Manager Testing Operations	Te Whatu Ora
Chris Scahill	Group Manager National Coordination & Response	Te Whatu Ora
Chrystal O'Connor	Group Manager National Investigation and Tracing Centre & Testing	Te Whatu Ora
Claire Whelan	Senior Advisor Strategy, Policy & Legislation	Manatū Hauora
Corina Grey	Chief Clinical Advisor Pacific Health	Manatū Hauora
Dan Bernal	Manager Science & Technical Advisory	Manatū Hauora
Dani Coplon	Critical Projects Lead Outbreak Response	Te Whatu Ora
Daniel Hirst	Group Manager Care in the Community	Te Whatu Ora



Interviewee	Role	Organisation
Dawn Kelly	Principal Advisor Office of Deputy Director-General	Manatū Hauora
Debbie Sinclair-Paton	Response Manager National Coordination & Response	Te Whatu Ora
Diego Montes	Senior Advisor National Immunisation Programme	Te Whatu Ora
Donna Gardiner	Former Chair Ngāti Ranginui Iwi Society Inc.	National Iwi Chairs Forum
Gina Anderson-Lister	General Manager System Performance Priorities	Manatū Hauora
Grace Davies	Policy Analyst, Māori Health, Strategy & Policy Māori Health Directorate	Manatū Hauora
Hayden McRobbie	Regional Director of Public Health, Northern National Public Health Service	Te Whatu Ora
Hycentha Uwikunda	Senior Advisor Intelligence & Analytics	Manatū Hauora
Ian Dodson	Chief Operating Officer HealthSource	Te Whatu Ora
Ian Long	Communications and Engagement National Immunisation Programme	Te Whatu Ora
Ian Town	Chief Science Advisor Evidence, Research & Innovation	Manatū Hauora
Jason Ake	General Manager, Communications & Engagement Waikato Tainui Chair Iwi Communications Collective	National Iwi Chairs Forum
Jennifer Keys	Chief Clinical Advisor	Te Whatu Ora
Jeremy Tuohy	Principal Advisor Science & Technical Advisory	Manatū Hauora



Interviewee	Role	Organisation
Jess Smaling	Associate Deputy Director-General System Performance & Monitoring	Manatū Hauora
Joe Bourne	Chief Medical Officer	Manatū Hauora
Joy Lancaster	Planning Lead COVID-19 PPE Supply Chain	Te Whatu Ora
Julia Ebbett	Lead Advisor COVID-19 Response Operational Design and Delivery	Whaikaha
Justine Lancaster	Former Clinical Lead Care in the Community	Manatū Hauora
Kate Baker	Former Communications Campaign Manager	Department of the Prime Minister and Cabinet
Kathrine Clarke	Principal Advisor Policy	Te Aka Whai Ora
Kieran Houser	Group Manager Hospital & Specialist Services	Te Whatu Ora
Kirk Mariner	Programme Director, Equity COVID-19– Testing & Supply	Te Whatu Ora
Kirsten Stephenson	Former General Manager, Office of the Deputy Chief Executive and Strategic Operations team COVID-19 Health System Response	Manatū Hauora
Louisa Rimmer	Campaign Team National Immunisation Programme	Te Whatu Ora
Mel Tata	Chief Executive Officer Ngāti Ranginui Iwi Society Inc.	National Iwi Chairs Forum
Natasha White	Regional Director of Public Health, Te Manawa Taki National Public Health Service	Te Whatu Ora
Priya Munro	Manager COVID-19 Communications	Te Whatu Ora
Rachel Mackay	Group Manager National Immunisation Programme	Te Whatu Ora



Interviewee	Role	Organisation
Richard Jaine	Deputy Director Office of the Director of Public Health	Manatū Hauora
Robert Humphrys	Manager, Logistics National Immunisation Programme	Te Whatu Ora
Siddhartha Mehta	Principal Advisor Intelligence & Analytics	Manatū Hauora
Steve Waldegrave	Associate Deputy Director-General Strategy, Policy & Legislation	Manatū Hauora
Vince Barry	Regional Director of Public Health, Te Wai Pounamu National Public Health Service	Te Whatu Ora
William Rainger	Medical Officer of Health	Auckland District Health Board

8.3 Appendix 3: List of documents reviewed

Title	Organisation
Aide-Mémoire, Lessons from the Omicron response to date 18/07/2022 (prepared by Department of the Prime Minister and Cabinet)	Manatū Hauora
Aide-Mémoire, Meeting with Vaccines Plus NZ representatives	Manatū Hauora
Appendix A – Summary of relevant reviews	Manatū Hauora
Appendix 1: Winter package of health measures	Manatū Hauora
Appendix 2: Additional information	Manatū Hauora
Appendix 3: Antiviral dispensing process and timeline	Manatū Hauora
Assessment of system pressures 2022 initiatives – emerging findings 7 th October 2022	Te Whatu Ora
Background information on review of National Immunisation Programme	Manatū Hauora
Briefing – COVID-19 Winter Surge Lessons Learned Scoping Plan 8 September 2022	Manatū Hauora
Briefing – COVID-19 Winter Surge Lessons Learned Scoping Plan 24 August 2022	Manatū Hauora
Briefing – Strengthening public health measures in response to increased COVID-19 infections and supporting wider winter wellness 8 July 2022	Manatū Hauora
Case Studies on Equity – How the Testing & Supply team demonstrate equity in action	Te Whatu Ora
Case Studies on Equity Volume 2 – How the Testing & Supply team demonstrate equity in action	Te Whatu Ora
COVID-19 management: where to from here?	Manatū Hauora
COVID-19 Mask Supply – 4 August 2022	Te Whatu Ora
COVID-19 Mask Supply – 11 August 2022	Te Whatu Ora
COVID-19 Mask Supply – 21 July 2022	Te Whatu Ora
COVID-19 Mask Supply – 28 July 2022	Te Whatu Ora
COVID-19 Mortality in Aotearoa New Zealand: Inequities in Risk	Manatū Hauora
COVID-19 Omicron Māori Provider – Optional feedback: Summary report	Manatū Hauora
COVID-19 Rapid Antigen Supply and Demand – 4 August 2022	Te Whatu Ora



Title	Organisation
COVID-19 Rapid Antigen Supply and Demand – 11 August 2022	Te Whatu Ora
COVID-19 Rapid Antigen Supply and Demand – 14 July 2022	Te Whatu Ora
COVID-19 Rapid Antigen Supply and Demand – 21 July 2022	Te Whatu Ora
COVID-19 Rapid Antigen Supply and Demand – 28 July 2022	Te Whatu Ora
COVID-19 Trends and Insights Report – 30 September 2022	Manatū Hauora
Delta Response Rapid Review Recommendations	Manatū Hauora
Delta Response Rapid Review Report for Ministry of Health (prepared by dovetail)	Manatū Hauora
Flu Vaccine Communications Concept Testing Results – Ministry of Health April 2022 (prepared by The Research Agency)	Te Whatu Ora
Flu Vaccine Communications 'TOUCH WOOD' Ad Testing Results – Ministry of Health May 2022 (prepared by The Research Agency)	Te Whatu Ora
Flu 2022 campaign activity summary	Te Whatu Ora
Immunisation Report 6 th June 2022	Te Whatu Ora
Immunisation Report 26 th September 2022	Te Whatu Ora
Independent Review of Māori Provider Distribution Channel (prepared by Allen + Clarke)	Manatū Hauora
Iwi Communications Collective COVID-19 hui minutes 3 rd September 2020	National Iwi Chairs Forum
Iwi Communications Collective COVID-19 hui minutes 27 th August 2020	National Iwi Chairs Forum
Iwi Communications Collective hui minutes 5 th August 2021	National Iwi Chairs Forum
Iwi Communications Collective hui minutes 10 th February 2022	National Iwi Chairs Forum
Iwi Communications Collective hui minutes 24 th March 2022	National Iwi Chairs Forum
Learnings from the Māori Influenza Vaccination Programme	Manatū Hauora
More than just a jab – Evaluation of the Māori influenza vaccination programme as part of the COVID-19 Māori health response December 2020 (prepared by Research Evaluation Consultancy)	Manatū Hauora
Omicron Māori provider feedback	Manatū Hauora



Title	Organisation
Omicron Māori provider reporting, 01 Apr 2022 to 05 Apr 2022 – Māori Health Insights 06 April 2022	Manatū Hauora
Omicron Māori provider reporting, 02 May 2022 to 06 May 2022 – Māori Health Insights 09 May 2022	Manatū Hauora
Omicron Māori provider reporting, 08 Sep 2022 to 21 Sep 2022 – Māori Health Insights 22 September 2022	Manatū Hauora
Omicron Māori provider reporting, 09 Apr 2022 to 13 Apr 2022 – Māori Health Insights 14 April 2022	Manatū Hauora
Omicron Māori provider reporting, 15 Aug 2022 to 02 Sep 2022 – Māori Health Insights 05 September 2022	Manatū Hauora
Omicron Māori provider reporting, 16 May 2022 to 20 May 2022 – Māori Health Insights 23 May 2022	Manatū Hauora
Post-Project Review Report – Pharmacist Supply COVID-19 Oral Therapeutics Project	Te Whatu Ora
Post-winter transition to a future of baseline and reserve measures	Manatū Hauora
Proactive Release – Lessons from the Omicron Response so far June 2022	Department of the Prime Minister and Cabinet
Rapid Review of Initial Operating Model and Organisational Arrangements for the National Response to COVID-19 – 23 April 2020	Chair of the Officials Committee for Domestic and External Security Coordination
Release, New measures to help manage COVID-19 as country stays at Orange	New Zealand Government
Reporting of the progress against Recommendations 30 th June 2021	Department of the Prime Minister and Cabinet
Seasonal Pressures – Survey Findings 2022	Te Whatu Ora
Second rapid review of the COVID-19 all-of-government response – October 2020	Chair of the Officials Committee for Domestic and External Security Coordination
System Pressures Assessment – Communications November 2022	Te Whatu Ora
System Pressures Assessment – Escalation Model October 2022	Te Whatu Ora
System Pressures Assessment – Executive Summary November 2022	Te Whatu Ora
System Pressures Assessment – Length of Stay November 2022	Te Whatu Ora
System Pressures Assessment – Primary Care October 2022	Te Whatu Ora



Title	Organisation
Therapeutics and winter surge planning	Te Whatu Ora
Trends and Insights Report – Updated 01 July 2022	Manatū Hauora
Trends and Insights Report – Updated 02 September 2022	Manatū Hauora
Trends and Insights Report – Updated 03 June 2022	Manatū Hauora
Trends and Insights Report – Updated 05 August 2022	Manatū Hauora
Trends and Insights Report – Updated 06 May 2022	Manatū Hauora
Trends and Insights Report – Updated 07 March 2022	Manatū Hauora
Trends and Insights Report – Updated 08 July 2022	Manatū Hauora
Trends and Insights Report – Updated 09 September 2022	Manatū Hauora
Trends and Insights Report – Updated 10 June 2022	Manatū Hauora
Trends and Insights Report – Updated 12 August 2022	Manatū Hauora
Trends and Insights Report – Updated 13 April 2022	Manatū Hauora
Trends and Insights Report – Updated 13 May 2022	Manatū Hauora
Trends and Insights Report – Updated 15 July 2022	Manatū Hauora
Trends and Insights Report – Updated 16 September 2022	Manatū Hauora
Trends and Insights Report – Updated 17 June 2022	Manatū Hauora
Trends and Insights Report – Updated 19 April 2022	Manatū Hauora
Trends and Insights Report – Updated 19 August 2022	Manatū Hauora
Trends and Insights Report – Updated 20 May 2022	Manatū Hauora
Trends and Insights Report – Updated 22 July 2022	Manatū Hauora
Trends and Insights Report – Updated 23 June 2022	Manatū Hauora
Trends and Insights Report Appendix Document – Updated 26 April 2022	Manatū Hauora
Trends and Insights Report – Updated 26 April 2022	Manatū Hauora
Trends and Insights Report – Updated 26 August 2022	Manatū Hauora
Trends and Insights Report – Updated 27 May 2022	Manatū Hauora
Trends and Insights Report – Updated 29 July 2022	Manatū Hauora



Title	Organisation
Ventilation in schools – Advice for schools and kura	Te Mahau (part of Te Tāhuhu o te Mātauranga, Ministry of Education)
Winter package of health measures (draft)	Manatū Hauora
Winter strategy for COVID-19 and other viruses 6 April 2022	Manatū Hauora
2022 Flu State of the Nation – Ministry of Health April 2022 (prepared by The Research Agency)	Te Whatu Ora

8.4 Appendix 4: Additional feedback from stakeholders in relation to equity

A number of comments were made by stakeholders which provide useful feedback on delivering equitable COVID-19 responses. While these comments were broader than the winter 2022 period, we have chosen to include a summary as they provide useful insights.

- Stakeholders told us that the level of iwi and Māori community confidence in the COVID-19 response was shaken when an external Māori Advisory Group was set up to advise on COVID-19 but was then disestablished.
- We heard that throughout the COVID-19 response, there was a reluctance to have more people at the table with differing opinions, due to the pressure to make quick decisions. Officials were constantly trying to balance the speed at which things needed to be completed, delivered and operationalised (often at the same time), as well as regularly having to pivot and change direction. This came at the cost of engagement and collaboration with vulnerable groups and partnership with Māori.
- Stakeholders felt that it had been raised early that vulnerable communities – especially tāngata whaikaha Māori and disabled people – have barriers to accessing health services, GPs, clinics and pharmacies. They felt too much emphasis was placed on health care expertise and not enough on how to equitably serve vulnerable communities. There was not enough flexibility for local solutions which would meet the needs of communities on the ground.

An example of this was local providers who tried to combine the flu and COVID-19 vaccinations to make it easy for whānau and using the opportunity of them presenting in a health setting to maximise vaccination uptake. However, this was only adopted as a position later in winter and up until that point rules, policies and funding did not support this occurring.

- Stakeholders told us that the predominant focus on COVID-19 messaging distracted from key messages around other health priorities for vulnerable communities. This meant people were not well equipped to deal with these health issues when they arose. An example of this was Pasifika men who disproportionately experience renal issues but messaging around this was not prominent – creating a lack of community support or resourcing to respond.
- We also heard from stakeholders that Manatū Hauora ‘throwing money at Trusts and hoping they do good’ was an unhelpful approach. This approach does not build the appropriate capacity, capability or provide information which will allow for ongoing quality services to communities.
- We were told that when engaging with Māori, officials needed to realise that community groups often had to support whānau with health issues but also support marae with tangihanga and other services. This needed to be taken into account in planning and setting expectations.
- We heard that genuine collaboration with communities to ensure quality health outcomes is paramount. While the functions of Te Whatu Ora and Te Aka Whai Ora are new and



the organisations are establishing new ways of working, we heard from stakeholders that the insights and positions these agencies take need to be respected and properly considered in the policy process. A lesson from winter 2022 was that collaboration takes time and is not meaningfully achieved when opportunities for feedback are limited, with short timeframes. Establishing collaborative ways of working as the default ensures that policies have system-level oversight, enables system-level strategic planning and reflects community concerns.

- Whaikaha expressed a concern that disabled people have become increasingly invisible during the pandemic – withdrawing from social settings to protect their safety. This meant disabled people had to manage for themselves the challenges of accessing medicines, RATs and health services. These difficulties were compounded if disabled people lived independently.
- We heard there is a paucity of outcome data specific to disabled people and tāngata Whaikaha Māori, with a greater focus placed on gathering insights and trends relating to Māori and Pacific communities.