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23 June 2023

s 9(2)(a) [redacted]

Ref: H2023025888

Tēnā koe s 9(2) [redacted]

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to Manatū Hauora (the Ministry of Health) on 25 May 2023. You requested:

> *All original communications regarding the following information:*
> *All briefings, reports, aide memoirs and memos around the Winter Preparedness Plan including, but not limited to all financial considerations, estimates and projections*

Manatū Hauora has identified two documents within scope of your request. The documents are itemised in Appendix 1 and copies of the documents are enclosed. Where information is withheld under section 9 of the Act, I have considered the countervailing public interest in releasing information and consider that it does not outweigh the need to withhold at this time.

Please note, additional information in scope of your request is more closely connected with the functions of the office of the Minister of Health, Hon Dr Ayesha Verrall. I have been advised that you lodged the same request to the Minister's office (AVOIA2023-146 refers). In preference to partially transferring your request pursuant to section 14(b)(ii) of the Act, I am referring you to the response from the office of the Minister of Health, which you can expect to receive in due course.

I trust this information fulfils your request. If you wish to discuss any aspect of your request with us, including this decision, please feel free to contact the OIA Services Team on: oiagr@health.govt.nz.

Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Manatū Hauora website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

Dr Andrew Old
Deputy Director-General
Public Health Agency | Te Pou Hauora Tūmatanui

Appendix 1: List of documents for release

#	Date	Document details	Decision on release
1	14 February 2023	Briefing – Decision to Use: Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine (bivalent vaccine) winter dose	Some information withheld under section 9(2)(a) of the Act, to protect the privacy of natural persons.
2	6 April 2023	Briefing – Drawdown of COVID-19 Response tagged contingency for 2023/24	Some information withheld under the following sections of the Act: • Section 9(2)(a), • Section 9(2)(b)(ii), where its release would likely unreasonably prejudice the commercial position of the person who supplied the information; and • Section 9(2)(f)(iv) to maintain the constitutional conventions that protect the confidentiality of advice tendered by Ministers and officials.

Document 1

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Decision to Use: Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine (bivalent vaccine) winter dose

Date due to MO:	14 February 2023	**Action required by:**	14 February 2023
Security level:	IN CONFIDENCE	**Health Report number:**	H2023019738
To:	Hon Dr Ayesha Verrall, Minister of Health		
Copy to:	Rt Hon Chris Hipkins, Prime Minister Hon Grant Robertson, Minister of Finance Hon Peeni Henare, Associate Minister of Health (Māori Health) Hon Barbara Edmonds, Associate Minister of Health (Pacific Health) Hon Willow-Jean Prime, Associate Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Alison Cossar	Manager, Public Health Policy and Regulation	s 9(2)(a) [redacted]
Dr Andrew Old	Deputy Director-General, Public Health Agency	s 9(2)(a) [redacted]

Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment:

MINISTRY OF HEALTH
MANATŪ HAUORA

Decision to Use: Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine (bivalent vaccine) winter dose

Security level:	IN CONFIDENCE	**Date:**	xxx
To:	Hon Dr Ayesha Verrall, Minister of Health		

Purpose of report

1. This briefing seeks your agreement to the use of Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine ("BA.4/5 bivalent vaccine") in the National Immunisation Programme (the Programme) from 1 April 2023 as a winter dose for:
    - anyone in the currently defined high-risk group eligible for a second booster dose who has completed a primary course [1], and regardless of the number of prior booster doses received, but who has not had a dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months, and
    - anyone aged 30 or over who has completed a primary course or received any number of booster doses but who has not had a booster dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months

Key points

2. Medsafe granted provisional approval for the BA1 and BA4/5 bivalent vaccines on 20 December 2022.
3. On 1 February 2023, you agreed to use the BA.4/5 bivalent vaccine in place of the original Pfizer vaccine for people who are currently eligible for a booster dose as the first part of the winter wellness campaign from 1 March 2023 [H2023019642 refers].
4. On 2 February 2023, the COVID-19 Vaccine Technical Advisory Group (CV TAG) met and reiterated their recommendation that the COVID-19 Immunisation Programme switch to bivalent vaccines, and that a second booster continue to be actively encouraged for adults who are currently eligible for free influenza vaccine in New Zealand.
5. CV TAG also recommended that all other people aged 30 years and over should be eligible to receive a second booster dose. These second booster doses should be administered from 6 months after the previous dose of a COVID-19 vaccine, and from 6 months after a SARS-CoV-

[1] People aged 65 years and over, Māori and Pacific peoples aged 50 years and over, residents of aged residential care and disability care facilities, severely immunocompromised people , people aged 16 years and over who have a medical condition that increases the risk of severe breakthrough COVID-19 illness and, people aged 16 years and over who live with a disability with significant or complex health needs or multiple comorbidities.

2 infection, with flexibility for the dose to be given from 3 months after a SARS-CoV-2 infection

6. In line with the Appendix of the CV TAG memo, 'Guiding Principles for future decisions around additional doses', Manatū Hauora is proposing to use the BA.4/5 bivalent vaccine in the Programme as an additional dose for both high-risk groups and all individuals aged 30 and over who have completed a primary course, regardless of the number of prior booster doses received.

7. Pharmac has confirmed the delivery of the initial 357,000 doses of BA.4/5 bivalent vaccine, with a similar number to follow by 31 March. A total of 1.7m doses will be available by 30 June 2023.

8. As noted above, bivalent vaccines will be available as boosters for those currently eligible from 1 March. Should you agree, we will implement the proposal for expanded eligibility from 1 April 2023 in alignment with the influenza vaccination programme and other winter wellness initiatives.

Recommendations

We recommend that you:

a) **Note** that on 1 February 2023, you agreed to use the BA.4/5 bivalent vaccine in place of the original Pfizer vaccine for people who are currently eligible for a booster dose as the first part of the winter wellness campaign from 1 March 2023 [H2023019642 refers].

b) **Note** that the COVID-19 Vaccine Technical Advisory Group (CV TAG) have met and discussed the use of Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine ("BA.4/5 bivalent vaccine") as a booster.

c) **Note** the 2 February 2023 CV TAG recommendations are that:

   a. Improving first booster coverage should be the top priority of the National Immunisation Programme

   b. In a winter vaccination programme, the groups recommended (i.e., actively encouraged) to receive a second booster dose should be expanded to include those eligible for free influenza vaccine in Aotearoa New Zealand. This is with the exception of the childhood age groups and pregnant people under the age of 30 that are part of free influenza vaccine eligibility.

   c. All people aged 30 years and over should be eligible to receive a second booster dose (i.e., can consider based on an individual risk benefit discussion with their immunisation provider). This expansion could be aligned with a winter campaign.

   d. These second booster doses should be administered from 6 months after the previous dose of COVID-19 vaccine,

and/or from 6 months after a SARS-CoV-2 infection, with flexibility for the dose to be given from 3 months after a SARS-CoV-2 infection (both criteria need to be fulfilled). Clinical discretion can be applied when considering vaccination prior to three months after infection for high-risk individuals.

e. The benefits of a second booster dose for people under the age of 30 years, who are otherwise healthy, is less certain. People in this group are encouraged to discuss their health needs and risks (e.g., risk of myocarditis or pericarditis) and benefits of a second booster dose with their health care provider.

f. The intervals between doses for Pfizer and Novavax COVID-19 vaccines (including BA.4/5 bivalent vaccines) should be interchangeable and consistent across vaccine schedules to simplify vaccination regimes.

d) **Note** that on 21 December 2022, Medsafe provisionally approved the BA.1 and BA.4/5 bivalent vaccines for use as a booster dose in individuals aged 12 years and over who have previously received a primary course of the original Pfizer vaccine, and for individuals aged 18 years and over who have completed a primary course with another COVID-19 vaccine, at least 5 months after the primary course and as early as 4 months after the last booster dose.

e) **Note** that Pharmac has confirmed the delivery of the initial 357,000 doses with the remaining Quarter 1 supply to be delivered by 31 March 2023 and another 1,042,000 doses to be delivered by 30 June 2023 (a total of 1.7 million doses of BA.4/5 bivalent vaccines in New Zealand).

f) **Note** That based on current modelling, there are no financial implications of purchasing the BA.4/5 bivalent vaccine until June 2023 as funding was previously drawn down to pay for the bivalent supply of 1.7 million doses.

g) **Agree** to the use of Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine ("BA.4/5 bivalent vaccine") in the National Immunisation Programme (the Programme) from 1 April 2023 as a winter dose for: **Yes/No**

- (recommended) anyone in the currently defined high-risk group eligible for a second booster dose, and regardless of the number of prior booster doses received, but who has not had a dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months, and

- (available) anyone aged 30 or over who has completed a primary course or received any number of booster doses but who has not had a booster dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months.

h) **Agree** to the proposed implementation plan provided in this briefing. **Yes/No**

Dr Diana Sarfati

Director-General of Health

Date: 13 February 2023

Hon Dr Ayesha Verrall

Minister of Health

Date: 19/2/23

Dr Andrew Old

Deputy Director-General

Public Health Agency

Date: 13 February 2023

Decision to Use: Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine (bivalent vaccine) winter dose

Background

9. Currently in New Zealand, first boosters (3rd dose) of original Pfizer COVID-19 vaccines are available for anyone aged 16 and over, and second boosters (4th dose) for anyone aged 50 or over, Māori and Pacific people aged 40 and over, healthcare workers aged 30 and over, and people aged 16 and over with serious medical conditions or disabilities. Eligibility is subject to time since last dose or infection. Novavax vaccines are available under similar circumstances, but a minimum age of 18 years.

10. On 21 December 2022, Medsafe provisionally approved the BA.4/5 bivalent vaccine for use as a booster dose in individuals aged 12 years and over who have previously received a primary course of the original Pfizer vaccine, and for individuals aged 18 years and over who have completed a primary course with another COVID-19 vaccine, at least 5 months after the primary course and as early as 4 months after the last booster dose.

11. The first shipment of bivalent vaccines arrived on 30 January 2023, with delivery schedule for Q1 (total 705,600 doses), with a further 1 million doses requested to be delivered early Q2.

12. On 1 February 2023, you agreed to use the BA.4/5 bivalent vaccine in place of the original Pfizer vaccine for people who are currently eligible for a booster dose as the first part of the winter wellness campaign from 1 March 2023 [H2023019642 refers].

International recommendations and experiences

13. The Australian Technical Advisory Group on Immunisation (ATAGI) released updated advice on boosters for 2023 on 8 February 2023. They **recommended** boosters for adults aged 65 and over, or adults aged 18 to 64 with medical comorbidities or disability with significant or complex health needs. Other adults aged 18 to 64 and children aged 5 to 17 with medical comorbidities or disability with significant or complex health needs should **consider** a booster dose.

14. The above advice applies to those whose last dose or infection occurred at least 6 months ago, regardless of the number of previous boosters.

15. Australia's approach is broader than our proposed approach as it includes young healthy adults aged 18 to 29. CV TAG considers that the benefits of a second booster for people aged under 30 are less certain, and people in that age group should discuss their health needs and risks (including the risks of myocarditis and pericarditis) with their health care provider.

16. The United Kingdom's Joint Committee on Vaccination and Immunisation is scaling back its booster programme for the time being, and from 12 February 2023, healthy adults aged 18 to 49 will not be eligible for an additional booster. They recommend another autumn

vaccination campaign in the second half of 2023[2], as well as a spring campaign for those most vulnerable.

17. While this is the opposite of our proposed approach, it reflects a different stage in the northern hemisphere seasonal cycle and population immunity following their booster campaign in late 2022.

18. Australia's advice recommends that autumn boosters be administered before June 2023, and it remains open to southern hemisphere countries to pause booster eligibility for healthy adults or revise the time period since last dose later this year.

19. Internationally, health officials have raised concerns about vaccine wastage and the need to make more carefully informed vaccine purchases as vaccine hesitancy continues to reduce uptake. Canada's introduction of BA.4/5 vaccines only 8 weeks after BA.1 vaccines has raised issues about vaccine redundancy, and in the United States, only 15.4% of people aged 5 years or older have received a BA.4/5 bivalent vaccine as of January 2023.

Eligibility for a winter bivalent COVID-19 vaccine

20. While New Zealand is experiencing decreasing COVID-19 infections at the current time, there remain over 170 people currently in hospital from COVID-19 associated conditions (13 February 2023).

21. Evolving strains of the COVID-19 virus raise the risk that existing vaccines will become less effective against infection or severe illness over time. The effectiveness of vaccines also reduces over time through waning immune response. However, with a large proportion of the New Zealand population having been infected over the last twelve months, a degree of hybrid immunity is reducing the size and impact of surges in COVID-19 infection rates.

22. Emerging variants such as CH.1.1, XBB.1.5 and BQ.1.1, which have been suggested as having more immune-evasive properties than previous Omicron variants, are more closely related to BA.5 than to BA.1. Therefore theoretically, this may suggest that BA.5-containing vaccines could confer greater protection against emerging variants for New Zealand.

Current CV TAG Review

23. CV TAG met on 2 February and made the following recommendations (Appendix 1):

    a. Improving first booster coverage should be the top priority of the National Immunisation Programme. In particular, the programme should prioritise those who are most at risk of severe disease and severe outcomes (including Māori and Pacific peoples with low first booster uptake).

    b. In a winter vaccination programme, the groups **recommended** (i.e., actively encouraged) to receive a second booster dose should be expanded to include those eligible for free influenza vaccine in Aotearoa New Zealand. This is with the exception of the childhood age

[2] Residents in a care home for older adults and staff working in care homes for older adults; frontline health and social care workers; all adults aged 50 years and over; persons aged 5 to 49 years in a clinical risk group, persons aged 12 to 49 years who are household contacts of people with immunosuppression; and persons aged 16 to 49 years who are carers.

groups and pregnant people under the age of 30 that are part of free influenza vaccine eligibility. See Appendix 3 for more information.

c. All people aged 30 years and over **should be eligible to receive** a second booster dose (i.e., can consider based on an individual risk benefit discussion with their immunisation provider). This expansion could be aligned with a winter campaign.

d. These second booster doses should be administered **from 6 months** after the previous dose of COVID-19 vaccine, and **from 6 months** after a **SARS-CoV-2 infection,** with flexibility for the dose to be given from 3 months after a SARS-CoV-2 infection (both criteria need to be fulfilled). Clinical discretion can be applied when considering vaccination prior to three months after infection for high-risk individuals

e. The benefits of a second booster dose for people under the age of 30 years, who are otherwise healthy, is less certain. People in this group are encouraged to discuss their health needs and risks (e.g., risk of myocarditis or pericarditis) and benefits of a second booster dose with their health care provider.

f. The intervals between doses for Pfizer and Novavax COVID-19 vaccines (including BA.4/5 bivalent vaccines) should be interchangeable and consistent across vaccine schedules to simplify vaccination regimes

24. While CV TAG noted they could not provide firm recommendations on additional doses after a second booster dose, they provide guiding principles for subsequent decisions in the section entitled **Future Considerations**.

Future considerations proposed by CV TAG

25. CV TAG has proposed the following guiding principles:

a. Improving first booster coverage should be the top priority of the National Immunisation Programme. In particular, the programme needs to prioritise those who are most at risk of severe disease and severe outcomes (including Māori and Pacific peoples with low first booster uptake).

b. Firm recommendations for additional doses beyond the first half of 2023 cannot be made currently due to uncertainty on the future epidemiology of COVID-19 (e.g., seasonality), future variants, and duration of protection against severe disease from hybrid immunity.

c. A flexible approach should be applied to current and future decisions on intervals between additional doses (boosters). This will provide the ability to adapt to changing variant, immunological, and epidemiological landscapes, as well as clinical decisions by an individual's healthcare provider.

d. Terminology should shift from the number of doses/boosters (i.e., first booster, second booster) towards terms such as 'additional doses' or 'autumn/annual vaccine doses', to minimise confusion and account for variations between populations.

e. Based on the likelihood of hybrid immunity providing protection against severe disease for many months, the potential programmatic advantages of aligning the COVID-19 vaccination programme to the winter influenza vaccination programme, as well as a need to mitigate the risk of over-burdening hospitals with winter respiratory illness, the Programme may be heading towards making an annual winter COVID-19 booster recommended (i.e. actively encouraged) for those at higher risk of severe COVID-19, and available (i.e. can be administered on request) to all those aged 30 and over.

f. Additional doses, such as a "third booster", (including more frequent doses for those at higher risk of severe COVID-19, or in high-risk epidemiological situations) could be considered in line with the following:

   i. For the general population, a schedule which has **six months or more** between additional doses should generally be implemented unless epidemiologically indicated (for example, a wave of severe COVID-19 is anticipated), in which case a schedule with as little as three months before a subsequent dose could be used. This includes the preferred interval between completion of the primary course and the first booster dose being six months or more. The previous three-month interval was based on epidemiological considerations at the time, which are no longer applicable to the current Aotearoa New Zealand situation. As above, schedules with longer intervals between additional doses (for example, twelve months after the previous dose) would be supported by this recommendation if the risk of severe COVID-19 remains low in the general population.

   ii. Current and future decisions on intervals between additional doses should also provide schedules for both those at higher risk of severe COVID-19 (e.g., the elderly, those with co-morbidities, and Māori and Pacific Peoples in high-risk age groups) and those at lower risk (e.g., those under 30 years of age). In general, higher risk groups would have a shorter recommended interval than the general population, and lower risk groups would have a longer interval. Some low-risk groups, such as young healthy children, may have no additional doses recommended until they reach a given age (or otherwise enter a group at higher risk of severe-COVID-19 disease)

g. An additional booster dose, if due, should be postponed for **at least three months, and preferably from six months, after SARS-CoV-2 infection.** Clinical discretion can be applied when considering vaccination prior to three months after infection. This may be appropriate for those individuals considered to be at high risk of severe disease from COVID-19 re-infection

Proposal for a winter dose

26. As a winter dose has been signalled in winter preparedness planning by Te Whatu Ora, consideration of the CV TAG Guiding Principles has been undertaken and the following approach is proposed:

   a. use of Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine ("BA.4/5 bivalent vaccine") in the National Immunisation Programme (the Programme) from 1 April 2023 as a winter dose for:

      i. **(recommended)** anyone in the currently defined high-risk group eligible for a second booster dose, and regardless of the number of prior booster doses received, but who has not had a dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months, and

      ii. **(available)** anyone aged 30 or over who has completed a primary course or received any number of booster doses but who has not had a booster dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months.

iii.

	Current eligibility – **second** booster	Proposed eligibility – **additional** booster at least six months following last dose or infection, regardless of number of previous boosters
Recommended	• People aged 65 and over • Māori and Pacific aged 50 and over • Residents of aged care and disability care facilities • Severely immunocompromised people • People aged 16 and over with a medical condition that increases the risk of severe COVID-19 • People aged 16 and over who live with a disability with significant or complex health needs	• People aged 65 and over • Māori and Pacific aged 50 and over • Residents of aged care and disability care facilities • Severely immunocompromised people • People aged 16 and over with a medical condition that increases the risk of severe COVID-19 • People aged 16 and over who live with a disability with significant or complex health needs
Available	• People aged 50 and over • Māori and Pacific people aged 40 and over • Healthcare, aged care and disability workers aged 30 and over	• People aged 30 and over

Rationale

27. A winter dose of the new bivalent vaccinations provides additional protection from severe disease and hospitalisation before the winter illness season begins.

28. CV TAG recommendations on the bivalent vaccine and Medsafe approval indicate the safety and efficacy of the bivalent vaccine as an additional dose, and particularly to those eligible who have not received a booster or have only had one booster.

29. While CV TAG is cautious regarding additional doses beyond a second booster, many eligible people are 6 to 12 months since their last dose, and possibly from their COVID infection.

Age group	Median days since last vaccination
5 to 15	183.5
12 to 15	266.5
16 to 29	332
30 to 39	336.5
40 to 49	327
50 to 59	324.5
60 and over	330

Median days since last vaccination dose (Source: National Immunisation Programme, 30 November 2022)

30. This means the majority of the vaccinated population aged 16 and older, are beyond, or are approaching, 12 months since their last vaccination dose for COVID-19.

31. Increasing immunity prior to the challenging winter season provides benefits beyond reducing illness and hospitalisations.

32. These benefits include:

    a. Reducing the potential burden on the health system, especially if COVID illness coincides with other winter respiratory illnesses

    b. Encouraging people to think about receiving other vaccinations, such as influenza.

33. While Australia is rolling out to people aged 18 years and over, CV TAG has suggested eligibility for the non-high-risk group to be 30 years and over. We support this analysis as there is still a risk of myocarditis in the younger age cohort and younger people have good recovery history.

34. CV TAG has recommended the post-infection interval to be at least three months, and preferably from six months, after SARS-CoV-2 infection. The proposal for the winter dose is 6 months post-infection with discretion for an earlier dose. While the impact of hybrid immunity is still emerging, 6 months post-infection is considered to likely provide a satisfactory level of protection.

Prior doses and moving towards a more routine COVID-19 vaccination programme

35. The proposed recommendation moves away from the language of booster doses and how many booster doses a person should have. In order to move to a new routine COVID-19 vaccination programme, and with emerging evidence of the safety of repeat doses, this winter dose will be available to people who cover the range of no boosters (but completed the primary course) to those who have had up to three boosters (immunocompromised).

36. It is envisaged that health officials will look to future doses as required, rather than the number of doses.

37. People outside these recommended/available groups can access the vaccine with a prescription from an authorised prescriber, ie. pregnant women under the age of 30 years, people living with disabilities with significant or complex health needs under the age of 16 years.

Influenza immunisation

38. Pharmac are responsible for setting the eligibility criteria for funded influenza immunisation. Typically, this includes people aged 65 and over, pregnant people, and people with certain serious health conditions. For 2022, they expanded eligibility criteria in response to the COVID-19 pandemic to include all children aged 3-12 years, Māori and Pacific people aged 55 to 64 years, and people with serious mental health and addiction conditions. Te Whatu Ora and the Public Health Agency have written to Pharmac seeking the continuation of these expanded criteria for the 2023 influenza immunisation programme. Pharmac's decision is forthcoming but will need to be made soon in time for this year's programme.

39. CV TAG's recommendation for COVID-19 boosters to match adult influenza vaccine eligibility helps simplify communication to encourage uptake, as well as reduce the burden on

healthcare systems. Consequently, more efficient use of resources could be achieved, along with a more effective vaccination campaign.

40. While we can support a significant proportion of people getting influenza vaccine to also get COVID-19 boosters at the same time, a perfect match between the two services would be difficult to achieve. For influenza, universal vaccination is encouraged but funded only for some. For COVID-19, booster vaccination is free for all, but recommended for some, available for others and discouraged for the remainder.

Equity

41. Equity recognises that different people with various levels of advantage require different approaches and resources to get equitable health outcomes.

42. Overall, Māori, Pacific and whaikaha peoples are impacted more by communicable diseases as well as the social and economic consequences of serious illness. The differential impact is expected to continue or increase as these communities have lower vaccination rates, higher rates of underlying health conditions and disabilities and high-contact living conditions. These communities may face inequitable access to appropriate healthcare services, be disproportionately impacted by COVID-19 and/or be at risk of more severe illness

43. Ongoing access to COVID-19 vaccines is essential to enable maximum protection for our population, particularly in the context of the evolving threat of COVID-19.

44. Māori and Pacific populations have been most affected by COVID-19 in the community to date, making up a disproportionate percentage of cases and age standardised hospitalisations and have a lower uptake of the COVID-19 vaccine.

45. As noted in the CV TAG advice, hospitalisation admissions in the third and fourth Quarter of 2022 were consistently higher among Māori and Pacific peoples aged 20 years and over in all age groups compared to Asian, European and Other ethnicities. Mortality risk for people aged 59 years and younger was 2.0 (95% CI 1.2–3.3) times higher for Māori and 1.8 (95% CI 1.0–3.5) times higher for Pacific people compared to European and Other groups after adjusting for sex, ages, ethnicity, comorbidity and vaccination status.

46. Ensuring there are safe and effective COVID-19 vaccines which are accessible in sufficient volumes enables the Programme to continue without delay and protect the most vulnerable groups at risk of harm from COVID-19.

47. Whānau-based approaches, alongside the provision of accessible vaccination services and communications, will provide an opportunity to improve delivery and uptake of the COVID-19 vaccine among Māori, Pacific and Tāngata whaikaha peoples as well as uptake of the wider National Immunisation Schedule.

48. Achieving equity for Māori, Pacific and whaikaha communities will be a major focus. Early engagement and targeted communications with these communities and the providers that work closely with them are the first steps. Preparing Māori, Pacific and disability providers and their vaccinating workforces will ensure capacity and capability is available to lead implementation in vulnerable communities before 1 April.

49. Ensuring equitable access to the bivalent vaccine for high-risk populations will continue to involve ensuring Māori and Pacific providers in particular are resourced and supported to deliver vaccination services to their communities. Ensuring access to vaccination services also includes addressing other barriers to health care services including cost and transport. Clear communication in appropriate languages and formats will be essential to providing

communities with the resources they need to make informed decisions in support of vaccination.

50. Equity groups in each Region will be established with the remit of monitoring uptake and supporting access to the vaccine for Māori and Pacific communities. Their activities to support implementation will include making data available to providers on the frontlines to guide responses at the community level, workforce development, and providing a communication channel between providers and the Programme. These groups will consist of local and national representatives from Te Whatu Ora, Te Aka Whai Ora, and the The National Immunisation Programme (the Programme).

Implementation and roll out

51. The Programme) has established a working group who are supporting the implementation planning for the Pfizer Comirnaty bivalent vaccine (the vaccine). Te Aka Whai Ora and Whaikaha are represented on this Working Group.

52. Te Whatu Ora regions have undertaken planning to support the COVID-19 Health System Response up to 30 June 2023. The planning is in accordance with the SWC and Cabinet decisions to secure and retain core COVID-19 services (7 December and 12 December 2022). As part of this planning, regions have identified providers, with a focus on Māori and Pacific providers, that they will contract with to deliver bivalent vaccinations.

53. The regions will utilise these providers to deliver bivalent vaccinations with a focus on equity. The Programme will work with National Public Health service (NPHS) and Te Whatu Ora Regional Directors, district SROs and immunisation leads to ensure demand is met.

54. In preparation for implementation on 1 April 2023, the Programme is working on the following areas:

    a. **Technical**: Work is underway to simplify Book My Vaccine. Following these changes, consumers will no longer be required to enter the date of their last dose when booking an appointment. The system update will also enable consumers to book for a COVID-19 vaccine and flu vaccine together, which will align with the winter preparedness campaign. The 6-month interval allows for people eligible for the BA.4/5 vaccine to receive it in time for winter, and at the same time as their flu vaccine.

    b. **Communications:** from a communications perspective, the Decision to Use advice allows clear and consistent messaging, as the dose interval is consistent across eligible populations. Current communications planning includes the reintroduction of messaging about staying up to date with COVID-19 vaccination, which will begin from late February. Initial campaigns will focus on Māori and Pacific, whaikaha communities and those in aged care. Following that there will be a wider campaign focusing on the general population.

    c. **Operational quality and safety:** Strong operational process settings are required to protect clinical safety with the introduction of the BA.4/5 vaccine. Considerable coordination is happening prior to the implementation. This includes the training of the vaccinator workforce, updating the Immunisation Handbook, clinical advice, operational guidelines, the informed consent form, and consumer collateral.

    d. **System capacity:** The primary focus is, and will continue to be, on ensuring equitable access to the BA.4/5 COVID-19 vaccine. This is done through engagement with Māori and Pacific health providers, as well as mobile and outreach teams. The Programme is

working with districts to ensure there is sufficient capacity to meet demand and are anticipating that a high proportion of boosters will be delivered through pharmacy and general practice.

e. **Workforce**: In 2022, for COVID-19 first boosters, 46% were delivered by pharmacy and 20% by General Practice. For the influenza vaccinations, 52% were delivered by general practice with 37% by pharmacy. Māori and Pacific providers also played a key role to deliver COVID-19 vaccinations also. It is anticipated primary care and pharmacy will continue to deliver the majority of COVID-19 boosters and influenza vaccinations. However, due to the recent announcement that general practice will no longer be funded for COVID-19 related consultations may impact access to general practice. In 2022, the Vaccinating Health Worker (VHW) role was introduced, where COVID-19 Vaccinators Working Under Supervision could transition to become a VHW and be able to administer a range of vaccines in addition to the COVID-19 vaccine. As of 7 February 2023, there are 100 VHWs who are able to administer COVID-19 and influenza vaccines (for those 12 years and over).

f. The Programme will work with the immunisation sector in the regions, districts and primary care to support the delivery of the winter wellness campaign.

g. **Stock**: If the Decision to Use recommendation is implemented, the total eligible population for the BA.4/5 vaccine is expected to be 2.35 million. Pharmac has confirmed the arrival of the initial supply of 59,520 vials (up to 6 doses in each vial) equivalent to 357,000 doses. Additional supply of 384,000 doses is expected to be received by 31 March 2023 with the Quarter 2 supply of 1.1 million doses to follow by 30 June 2023. The total expected supply of BA.4/5 bivalent vaccines in New Zealand is 1.7 million doses. Of this, 43,000 doses are earmarked for the Pacific Islands.

The table below outlines the volumes based on 40% to 80% uptake:

	Total eligible population	40%	50%	60%	70%	80%
30y +	2,355,572	842,229	1,177,786	1,413,343	1,648,900	1,884,457

To date, 73% of the eligible population (18 years +) have received a COVID -19 first booster, and 48% of the eligible population (50+) received a COVID-19 second booster.

Officials expect that bivalent vaccine deliveries will continue regularly throughout Q1 and 2, with exact vaccine delivery dates set four weeks in advance. Pharmac and the National Immunisation Programme will continue to monitor uptake and stock levels. While at this stage it is not expected to be any periods of scarcity, if necessary it may be able to negotiate earlier delivery dates.

Financial Implications

55. Based on current modelling, we do not expect any financial implications of purchasing the BA.4/5 bivalent vaccine until June 2023 as funding was previously drawn down to pay for the bivalent supply of 1.7 million doses.

Next steps

56. If you agree to the recommendations in this briefing, officials will progress implementation plans and confirm delivery schedules with Pharmac.

ENDS.

MINISTRY OF HEALTH
MANATŪ HAUORA

Minister's Notes

Document 2

MANATŪ HAUORA
MINISTRY OF HEALTH

Briefing

Drawdown of COVID-19 Response tagged contingency for 2023/24

Date due to MO:	6 April 2023	**Action required by:**	11 April 2023
Security level:	IN CONFIDENCE	**Health Report number:**	H2023022618
To:	Hon Grant Robertson, Minister of Finance Hon Dr Ayesha Verrall, Minister of Health		
Consulted:	Health New Zealand: ☐ Māori Health Authority: ☐		

Contact for telephone discussion

Name	Position	Telephone
Stephen Glover	Group Manager COVID-19, Strategy, Policy and Legislation	s 9(2)(a) [redacted]
Maree Roberts	Deputy Director-General, Strategy, Policy and Legislation	s 9(2)(a) [redacted]

Minister's office to complete:

☐ Approved	☐ Decline	☐ Noted
☐ Needs change	☐ Seen	☐ Overtaken by events
☐ See Minister's Notes	☐ Withdrawn	

Comment:

Drawdown of COVID-19 Response tagged contingency for 2023/24

Security level:	IN CONFIDENCE	**Date:**	6 April 2023
To:	Hon Grant Robertson, Minister of Finance Hon Dr Ayesha Verrall, Minister of Health		

Purpose of report

1. This paper seeks decisions from Ministers on an allocation and draw down from the remaining $450.0 million in the COVID-19 Response tagged contingency.

Summary

2. In Budget 2022, the Government established a COVID-19 Response tagged contingency (tagged contingency) of $1.202 billion. In December 2022, Cabinet agreed to draw down $378.488 million from the tagged contingency to meet public health costs of the COVID-19 response in the 2022/23 financial year. Cabinet also authorised the Ministers of Finance and Health to take decisions on any further funding requests from the tagged contingency. Following reprioritisation to meet costs arising from Cyclone Gabrielle, there is $450.0 million remaining in the tagged contingency.

3. Ministers are asked to approve the net drawdown of $183.908 million from the tagged contingency to enable Pharmac and Te Whatu Ora to undertake contract negotiations and secure the resourcing required to deliver COVID-19 response activities in 2023/24.

4. The COVID-19 response proposed in this paper has been "right-sized" to reflect the risks presented by COVID-19 at this stage in the outbreak. It targets additional support to the communities at greatest risk of serious illness from COVID-19, including Māori, Pacific peoples, disabled peoples, the elderly and the otherwise clinically vulnerable. People outside of these cohorts are now able to manage the impact of COVID-19 supported by "business-as-usual" health services.

5. Funding is sought to deliver this response, to:

   a. complete the current 2023 winter wellness vaccination campaign and continue delivery of a baseline vaccination programme post winter; it also provides for a further winter wellness vaccination campaign in 2024, if this is recommended by the COVID-19 Vaccination Technical Advisory Group (CVTAG)

   b. purchase sufficient antiviral courses to ensure that Aotearoa's most vulnerable populations retain access to this treatment to significantly reduce their risk of becoming seriously ill as a result of a COVID-19 infection

   c. ensure eligible New Zealanders can access vaccinations, antivirals, and other necessary supports in a timely manner through additional COVID-19 services in primary care

d. maintain a minimum level of system preparedness and resilience (including laboratory capacity, surveillance and stocks of personal protective equipment) to respond to future COVID-19 waves or variants.

Recommendations

We recommend you:

a)	**Note** that the Government established the COVID-19 Response tagged contingency (tagged contingency) in Budget 2022 with an initial balance of $1.202 billion.	**Noted**
b)	**Note** that, in December 2022, Cabinet agreed to draw down $378.488 million from the tagged contingency to meet public health costs of the COVID-19 response in the 2022/23 financial year [SWC-22-MIN-0239].	**Noted**
c)	**Note** that Cabinet also authorised joint Ministers of Finance and Health to take decisions on any further funding requests from the tagged contingency [SWC-22-MIN-0239].	**Noted**
d)	s 9(2)(f)(iv) [redacted]	**Noted**
e)	**Note** that, following reprioritisation to support the response to Cyclone Gabrielle, $500 million remains in the tagged contingency, of which $50 million has been set aside for the Leave Support Scheme.	**Noted**
f)	**Note** that the COVID-19 response has been "right-sized" to reflect the risks presented by COVID-19 at this stage in the outbreak, focusing additional support on the communities at greatest risk of serious illness from COVID-19.	**Noted**
g)	**Agree** to fund the purchase of additional vaccine doses and antiviral treatments by drawing down s 9(2)(b)(ii) [redacted] in 2022/23 and s 9(2)(b)(ii) [redacted] in 2023/24 from the tagged contingency into Vote Health.	**Yes/No**
h)	**Agree** to fund the delivery of the National Immunisation Programme by carrying forward the underspend for the COVID-19 Immunisation programme as noted in recommendation d) and allocating $129.918 million towards the COVID-19 Immunisation Programme in the 23/24 financial year and reprioritise the remaining underspend of s 9(2)(b)(ii) [redacted] to reduce the additional funding needed to meet the cost of purchasing antivirals in the current year.	**Yes/No**
i)	s 9(2)(f)(iv) [redacted]	**Noted**
j)	**Approve** the following changes to appropriations to provide for the decisions in recommendations g, and h above, with a corresponding impact on the operating balance and net debt.	**Yes/No**

Vote Health Minister of Health	$ millions – increase/(decrease)				
	2022/23	2023/24	2024/25	2025/26	2026/27 & Outyears
Multi-Category Expenses and Capital Expenditure: Implementing the COVID-19 Vaccine Strategy (MCA) Non-departmental Output Expense:					
Implementing the COVID-19 Immunisation Programme	(149.210)	129.918	-	-	-
Purchasing Potential and Proven COVID-19 Vaccines and Other Therapeutics	s 9(2)(b)(ii)		-	-	-
Total Operating			-	-	-

k) **Agree** that the changes to appropriations for 2022/23 above be included in the 2022/23 Supplementary Estimates and that, in the interim, the increase be met from Imprest Supply. **Yes/No**

l) **Agree** that the funding approved in recommendation j) above be charged against the COVID-19 Response tagged operating contingency detailed in recommendation a) above. **Yes/No**

m) **Direct** officials to provide further advice to joint Ministers on the forecast cost for continuing the COVID-19 Public Health Response, as highlighted in recommendation i) above. **Yes/No**

n) **Note** that officials will report back to the Minister of Health in June 2024 on options for transitioning future COVID-19 vaccine and therapeutics purchasing into Pharmac's Combined Pharmaceuticals Budget as part of the Budget 2024 process. **Noted**

Hon Grant Robertson
Minister of Finance
Date:

Hon Dr Ayesha Verrall
Minister of Health
Date: 11/4/23

Maree Roberts
Deputy Director-General
Strategy, Policy, and Legislation
Date: 6 April 2023

Drawdown of COVID-19 Response tagged contingency for 2023/24

Background

1. In Budget 2022, the Government established a COVID-19 Response tagged contingency (tagged contingency) of $1.202 billion. In December 2022, Cabinet agreed to the drawdown of $378.488 million from the tagged contingency to fund COVID-19 response activities for the period January to June 2023 [SWC-22-MIN-0239 refers]. Cabinet also authorised joint Ministers of Finance and Health to take decisions on any further funding requests from the tagged contingency.

2. Cabinet directed officials to report back to joint Ministers (of Health and Finance) on the funding required for COVID-19 related services and activities for the June to December 2023 period. This paper provides that report back.

3. Cabinet also invited you to report back to the Cabinet Social Wellbeing Committee with the future COVID-19 strategy and advice and options for the future of currently funded services and activities [SWC-22-MIN-0239 refers]. A paper has been prepared to provide these report backs and is expected to be considered in May 2023.

4. Due to reprioritisation of funds from the tagged contingency to meet costs arising from Cyclone Gabrielle, there is $500.0 million remaining in the tagged contingency, of which $50.0 million has been set aside for the continuation of the Leave Support Scheme. Ministers are asked to agree to the drawdown of s 9(2)(f)(iv) [redacted] before the Budget Moratorium to enable Pharmac and Te Whatu Ora to undertake contract negotiations and secure the resourcing required to deliver COVID-19 therapeutic and COVID-19 immunisation activities in 2023/24.

Funding our COVID-19 response through 2023/24

5. The proposals in this paper reflect a relatively benign outlook for COVID-19. We now have high levels of immunity, better access to antivirals, improved surveillance and diagnostics, and open borders. We also have a better understanding of the virus.

6. COVID-19 Modelling Aotearoa (CMA) modelling projects that case numbers are likely to remain low over winter with a central scenario of around 2,100 new cases per day and no new waves or surges in cases. Even under the 'High' scenario of around 4,000 new cases per day, this would be well below the levels of COVID-19 seen over winter 2022 (peaking at 6,300 cases per day between June and August 2022).

7. In this context, most people can manage the impact of COVID-19 with access to their usual health services. At the same time, additional support is targeted the communities at greatest risk of serious illness from COVID-19, including Māori, Pacific peoples, disabled peoples, the elderly and the otherwise clinically vulnerable. The services proposed in this report are designed to work together to ensure these cohorts can access vaccinations, antivirals, and other necessary supports in a timely manner.

Implementing the COVID-19 Vaccine Strategy (MCA)

8. COVID-19 vaccinations are a critical tool for the long-term management of COVID-19. Vaccination acts as the primary prevention measure to help ensure burden on the health system is minimised, our communities are protected, and those who are vulnerable feel safe.

9. Funding is sought for a vaccination programme that will enable the completion of the current 2023 winter wellness campaign, the maintenance of a "baseline" vaccine programme from October 2023 to March 2024, at s 9(2)(b)(ii) and the delivery of a 2024 winter wellness campaign.

Implementing the COVID-19 Immunisation Programme

10. Funding of $129.918 million is sought for to implement the COVID-19 Immunisation Programme. This would allow for the completion of the current 2023 winter wellness campaign and the maintenance of a baseline programme for the October 2023 to June 2024 period of 15,000 vaccinations per month (435,000 doses delivered). The funding would also support the delivery of a 2024 winter wellness campaign, if a decision is made to deliver one, with an expected uptake by 50 percent of the high-risk population groups in the March to June 2024 period (an additional 820,000 doses delivered).

11. Te Whatu Ora's proposed delivery model will remain focussed on outreach services that address existing gaps in priority populations and tailor the expected delivery volume in line with the current uptake trends. Delivery outside of outreach services will continue to be provided through pharmacy and primary care clinics.

12. Due to lower than expected uptake levels, funding provided for the COVID-19 Immunisation Programme for the 22/23 financial year will not be fully utilised, leaving a forecast s 9(2)(f)(iv) unspent and available to be carried forward into the 23/24 financial year. Therefore, I recommend Ministers agree to carry forward funding of $129.918 million from the 22/23 financial year into the 23/24 financial year for the COVID-19 Immunisation Programme. This will allow the government the flexibility to make decisions on a winter 2024 campaign once the CVTAG provides advice on the minimum time that individuals should wait before receiving further (i.e. 'third' booster or subsequent doses) booster doses. Manatū Hauora intends to seek advice from the CVTAG in the near future to enable Pharmac to initiate purchasing negotiations well in advance of any winter 2024 campaign.

13. The remaining underspend in the 22/23 financial year, which will not be required to fund the COVID-19 Immunisation Programme in 23/24, is s 9(2)(b)(ii) I recommend that Ministers agree that this funding be transferred into the Purchasing Potential and Proven COVID-19 Vaccines and Other Therapeutics and utilised to reduce the amount of new funding required for the purchase of therapeutics in the current financial year. Manatū Hauora will report back to joint Ministers in June 2024, alongside the In Principle Expense Transfers process, to identify how any changes to the forecast underspend is managed [SWC-22-MIN-0239 refers].

Table 1: Proposed costs for Implementing the COVID-19 Immunisation Programme 2023/24

Implementing the COVID-19 Immunisation Programme	Cost	Forecast Underspend 2022/23	Total funding repurposed to Purchasing Potential and Proven COVID-19 Vaccines and Other Therapeutics
Winter wellness 2023	76,861	s 9(2)(b)(ii)	
Winter wellness 2024	53,057		
Total	**129,918**		

Purchasing vaccines and therapeutics

Vaccines

14. We currently have 1,841,616 vaccine doses in New Zealand (1,678,956 in warehouses and 162,660 at sites around the country) for use in the 2023 winter wellness campaign. Pharmac will need to purchase additional courses between May and September 2023 to sustain the vaccination programme, which can be met out of existing appropriations.

15. I recommend Ministers agree to s 9(2)(b)(ii) for the purchase of s 9(2)(b)(ii) doses (120,000 vials) of the bivalent booster needed to provide for the expected uptake for the remainder of the year, at an average of s 9(2)(b)(ii) for the October 2023 – June 2024 period, factoring in normal wastage. A further s 9(2)(b)(ii) will also allow for the purchase of s 9(2)(b)(ii) more bivalent doses s 9(2)(b)(ii) if a decision is made to deliver a 2024 winter campaign.

16. In addition to providing booster doses, Pharmac will require funding for the purchase of vaccinations for those cohorts aging into eligibility for their primary vaccination. I recommend Ministers agree to funding and drawdown of s 9(2)(b)(ii) to purchase s 9(2)(b)(ii) doses of the adult monovalent vaccine and s 9(2)(b)(ii) million to purchase s 9(2)(b)(ii) doses of the paediatric vaccine.

17. Officials note that if uptake through the 2023 winter wellness campaign is higher than expected, there is a risk that the vaccination programme may not have sufficient doses to meet demand and funding tagged for the 2024 winter wellness campaign may need to be utilised earlier.

Therapeutics

18. COVID-19 antiviral medicines remain the primary method of reducing the risk of severe illness, hospitalisation, and death from COVID-19 for some of Aotearoa's most vulnerable populations (including older people and Māori). The clinical evidence supports the use of Nirmatrelivr-ritonavir (Paxlovid) as the first line of treatment for COVID-19 in New Zealand. Officials have projected expected usage of antivirals, based on modelling case numbers and expected take-up, including relatively lower demand post-winter.

19. Pharmac has analysed usage from the period when access criteria were most recently widened (14 September 2022) to determine the proportion of cases expected to receive antivirals and used Te Whatu Ora modelling to estimate the number of likely cases. Currently 14.7 percent of COVID-19 cases are dispensed a course of antivirals within their

first five days (2,509 courses dispensed the week ending 26 March 2023), which equates to around 32,500 courses dispensed per quarter at current case rates.

20. Pharmac anticipates having approximately 15,800 courses of Paxlovid on hand at the end of the 2022/23 financial year. Funding is sought to purchase an additional s 9(2)(b)(ii) courses of Paxlovid s 9(2)(b)(ii) to meet expected demand over 2023/24.

21. I also recommend funding the purchase of s 9(2)(b)(ii) of Remdesivir s 9(2)(b)(ii) enough for approximately s 9(2)(b)(ii) individuals, as a second-line option where an alternative is needed for patients who cannot take Paxlovid due to contraindications.

22. I recommend that Ministers agree to the drawdown of s 9(2)(b)(ii) in 2022/23 from the tagged contingency for the net cost of purchasing s 9(2)(b)(ii) courses of Paxlovid for use in the first quarter of 2023/24. I also recommend that Ministers agree to the drawdown of a further s 9(2)(b)(ii) from the tagged contingency for the purchase of therapeutics over the course of 2023/24.

Table 2: Proposed costs for the purchasing of vaccines and therapeutics 2022/23 and 2023/24 ($m)

Purchasing Potential and Proven COVID-19 Vaccines and Other Therapeutics	Cost	Forecast Underspend 2022/23	Total funding requested for 2022/23	Total funding requested for 2023/24
Primary vaccine doses	s 9(2)(b)(ii)			
Bivalent booster doses				
Therapeutics				
Funding repurposed from implementing the COVID-19 Immunisation Programme				
Total				

National Response to COVID-19 Across the Health Sector (MCA)

COVID-19 Public Health Response

Care in the Community

23. Care in the Community was established to manage the increased levels of COVID-19 in the community and to minimise the burden on our health system. The programme acknowledges the necessary collaboration between the 4 health service pillars (public health, primary care, community care and secondary and) and welfare to ensure safe, effective and equitable care at home. The funding sought for 2023/24 will enable the prioritisation of the delivery of services to those individuals and whānau who are most affected by COVID-19 within the community.

24. After winter 2023, the Auckland hubs and other supports will be scaled down, but a small additional capacity is provided for in Northland and the Auckland Kaupapa Māori hubs. Funding for Alternate Isolation Accommodation ends from 1 October 2023 (or earlier if the mandatory requirement to self-isolate is ended prior to this date). Funding of $87.3 million is sought for Care in the Community for 2023/24.

Māori, Pacific and Disability COVID-19 wraparound services

25. Funding of $17.1 million for Māori, Pacific and disability COVID-19 wraparound services will enable the continued delivery of whanau-centred and other wraparound COVID-19 health services through to the end of 2023 including:

    a. access to vaccination and testing services

    b. wraparound services, including health and social support for cases, families, and those isolating at home

    c. bespoke communications including recommunicating key messages in a culturally appropriate manner, collaborative approaches to communication, and 0800 telephone lines to provide support for Pacific families.

26. From 1 January 2024, these services will be delivered from Te Whatu Ora and Te Aka Whai Ora baselines.

Testing and Laboratory Services

27. Testing remains a key enabler for the COVID-19 response. The $97.4 million sought will enable the continued payment of primary care consultation costs under current eligibility criteria until 30 September 2023. From 1 October 2023, eligibility for these payments will be aligned with antiviral eligibility. Laboratory PCR processing capacity will be purchased on a "fee per test" basis from 1 July 2023. The funding sought will enable the system to purchase up to 1,500 PCR tests per day from July to November (current 7-day average is 1,028 tests per day). We expect this to reduce to 1,000 per day from November through to the end of June 2024. Within this funding envelope, significant surge capacity for PCR processing will not be retained.

28. Current stock on hand enables the distribution of free RATs to the public to continue until the end of 2023. Community testing infrastructure is retained from 1 July 2023 with 15 community providers until October and focused on deprivation areas from October through until 1 December 2023. There is no funding for further rapid antigen test (RAT) purchases.

29. Ongoing surveillance would be supported by the continued whole genomic sequencing of 400 samples per week with a surge capacity of up to 1,000 PCR samples per week. Wastewater testing is retained across the country through to June 2024.

Telehealth

30. Funding of $24.0 million for Telehealth would maintain a baseline capacity through winter 2023 with a reduced capacity from October to December 2023 (or earlier if mandatory requirements for isolation are removed prior to the end of winter). This will retain capacity to respond to inbound calls and end outbound calls for case investigations. From 1 January 2024, a single COVID-19 Helpline would be in place to receive inbound calls.

National Investigation Centre

31. The National Investigation Centre (NIC) provides the personnel and systems to ensure that we can accurately investigate cases and clusters to determine the likely spread of the virus within New Zealand. The funding sought would maintain the current service delivery model until the end of winter. From October 2023, NIC capacity will be transitioned to sit under Te Whatu Ora's broader communicable disease management capability for the period of January to June 2024.

Personal Protective Equipment

32. A phased pathway to transition from COVID-19 personal protective equipment (PPE) supply settings to pre-pandemic purchasing of PPE from 1 October 2023 is proposed to:

a. allow Te Whatu Ora to run stock levels down to a 12-week holding level and manage obsolescence risk

b. ease provider reliance on centrally provided and funded PPE, and allow the private market time to meet increased demand

c. continue to support remaining COVID-19 response settings, within available funding.

33. This transition pathway involves the prepurchase of a small volume of PPE in July 2023 to boost stock and ensures maintenance of a minimum 12-week high pandemic use level of stock. Central supply will cease from 1 October 2023 on a product-by-product basis when stock drops to the 12-week holding level or from 1 January 2024 at the latest. At that point, all service providers would be required to fund their own PPE supply.

Implementing the COVID-19 Public Health Response

34. The table below outlines the requested funding for the COVID-19 public health response across these areas for the 2023/24 financial year. The funding sought to implement the COVID-19 public health response is unlikely to be sufficient to manage a surge or wave like the one experienced in winter 2022 and responding to a surge or wave may strain New Zealand's healthcare system.

Table 3: Proposed costs of the COVID-19 Public Health Response 2023/24 ($m)

COVID-19 Public Health Response	Cost	Forecast (Underspend) / Overspend 2022/23	Total funding requested for 2023/24
Care in the Community	87.300	22.590	109.890
Māori and Pacific Services	17.100	(6.205)	10.895
Testing and Laboratory Services	97.400	25.150	122.550
Telehealth	24.000	(9.540)	14.460
National Investigation Centre	6.900	(10.400)	(3.500)
Personal Protective Equipment	23.100	(0.059)	23.041
Alternate Accommodation	-	(0.580)	(0.580)
Te Whatu Ora Corporate Support	-	(19.060)	(19.060)
Total	**255.800**	1.896	**257.696**

35. Further advice will be prepared for Ministers on the amount that should be drawn down from the tagged contingency in 2023/24 to implement the COVID-19 public health response.

Next steps

36. If Ministers agree to the recommendations in this paper, officials will reflect those decisions in the paper 'Aotearoa New Zealand Strategic Framework for Managing COVID-19', which is due to be considered by the Cabinet Social Wellbeing Committee on Wednesday 3 May 2023.

37. Officials will seek advice from the CVTAG in the near future to confirm their advice on frequency and eligibility for future doses, to enable Pharmac to initiate purchasing negotiations well in advance of any winter 2024 campaign.

38. Te Whatu Ora, Manatū Hauora and the Treasury will provide further advice on the funds required to continue the COVID-19 Public Health Response.

39. Manatū Hauora will report back to joint Ministers in June 2024, alongside the In Principle Expense Transfers process, to identify how any changes to the forecast underspend in the Implementing the COVID-19 Vaccine Strategy MCA is managed. Officials will also report back to the Minister of Health on options for transitioning future COVID-19 vaccine and therapeutics purchasing into Pharmac's Combined Pharmaceuticals Budget, and any associated impacts on the National Immunisation Programme, for consideration as part of the Budget 2024 process.

40. Manatū Hauora will work with Te Whatu Ora to ensure that COVID-19 response activities beyond January 2024 can be delivered within baselines and as part of Budget 2024 proposals.

ENDS.

Minister's Notes