What is the policy problem or opportunity?

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

The Ministry of Health has reviewed the legislative framework in the Orders that sit under the COVID-19 Public Health Response Act 2020 for the ongoing management of the public health response. This is to ensure the response remains effective, justifiable and proportionate under the Bill of Rights Act 1990.

In particular, the measures that were considered are:

1. the requirement to provide information by air arrivals for COVID-19 contact tracing
2. the 7-day case isolation requirement
3. point of care tests regulation
4. the current masking requirements in healthcare settings.

It is important to note that these measures do not operate in isolation. They are supported by a number of "baseline" measures that do not require Orders (and by extension are not the directly in the scope of this document). Specifically:

- s9(2)(f)(iv) [redacted]
- Access to vaccination.
- Access to antiviral medications (for those at risk of serious illness).
- Availability of free masks and rapid antigen tests for the general public.
- Availability of free N95 type masks for people at high risk of severe outcomes.

The measures considered were reviewed in the context of the current and likely short term COVID-19 risk, therefore the scope of options considered:

- includes the status quo and stepping down alternatives, in light of the ongoing reduction in the COVID-19 risk
- implicitly, but not directly, assesses the consistency of the proposed changes to COVID-19 policy settings with the Variants of Concern Strategic Framework (published 23 June 2022).[1]

Who are the stakeholders in this issue, what is the nature of their interest, and how are they affected? Outline which stakeholders share your view of the problem, which do not, and why. Have their views changed your understanding of the problem?

The ongoing response to COVID-19 effects everyone in Aotearoa New Zealand, however certain groups are more at risk due to clinical or equity-based reasons (and this is explored below). The response also requires ongoing support from business and communities to ensure the public health response remains effective.

[1] https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-response-planning/variants-concern-framework-summary

In seeking to remain proportionate, we continue to balance public health risk against the need to minimise any compulsory measures and any associated impost.

DPMC has carried out engagement based on draft public health advice with the Strategic Public Health Advisory Group, representatives from nine disability groups, members of the National Iwi Chairs Forum (NICF) and the Regional Leadership Groups (RLGs).

The Strategic Public Health Advisory Group discussed the limitations of using personal experience to understand compliance or the effectiveness of public health measures, and emphasized the importance of social science to understand community attitudes. They also noted that their highest risk patients regularly visit pharmacies, in relation to mask requirements. Members also noted the value of considering COVID-19 in the context of other respiratory illnesses generally, rather than in isolation.

The NICF supports retaining self-isolation for cases, while expressing concerns with regards to the reach and communication of support surrounding self-isolation, with COVID-19 cases potentially questioning their eligibility.

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

RLGs had mixed views on retaining or removing government mask mandates. While many supported a precautionary approach, particularly in healthcare settings where immunocompromised people attend, it was noted that businesses and services should make decisions on mask use that are appropriate to their circumstances. There was support for masks and mask guidance continuing to be made readily available

RLGs also had mixed views on retaining or reducing case isolation. A majority supported test-to-release case isolation or retaining seven days, as this was thought to protect the health system and the health and welfare of people, particularly elderly people who may not be recovering as quickly as the general population. Some RLGs pointed out that retaining some isolation would avoid needing to stand up isolation again in the near future. However, compliance with case isolation was questioned with some RLGs noting low compliance among cases that have important events to attend, pressure from employers, and financial concerns. A small proportion was supportive of treating COVID-19 like any other virus and therefore removing isolation requirements all together.

Public Health Risk Assessment consultation

In September 2022, feedback was sought from stakeholders representing groups at greater risk to the effects of COVID-19 (Pacific Peoples, Māori and Disabled Peoples). Stakeholder engagement was undertaken to inform the Public PHRA held 03 October 2022. Stakeholders included approximately 50 individuals representing the following sectors: NGOs, Tertiary Education Institutes, Health Professionals, Community Groups, Health Service Providers and subject matter experts within government agencies.

Across the board there was strong support for retaining the current mandated measures to protect vulnerable communities. The move away from the Elimination Strategy and removal of other mandatory requirements were considered to put Pacific, Māori and Disabled communities at greater risk.

Generally, these stakeholders expressed concern that if restrictions were removed, the community at large may not take the risk of COVID-19 seriously and put vulnerable populations at greater risk.

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

Across the health system, Māori and Pacific peoples are more at risk of negative health outcomes than non-Māori non-Pacific Peoples of the same age, and are also more likely to experience greater disease exposure. Similarly, those experiencing socio-economic disadvantage are at greater risk of severe negative health outcomes than affluent people of the same age, and are also more likely to experience greater disease exposure.[2]

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

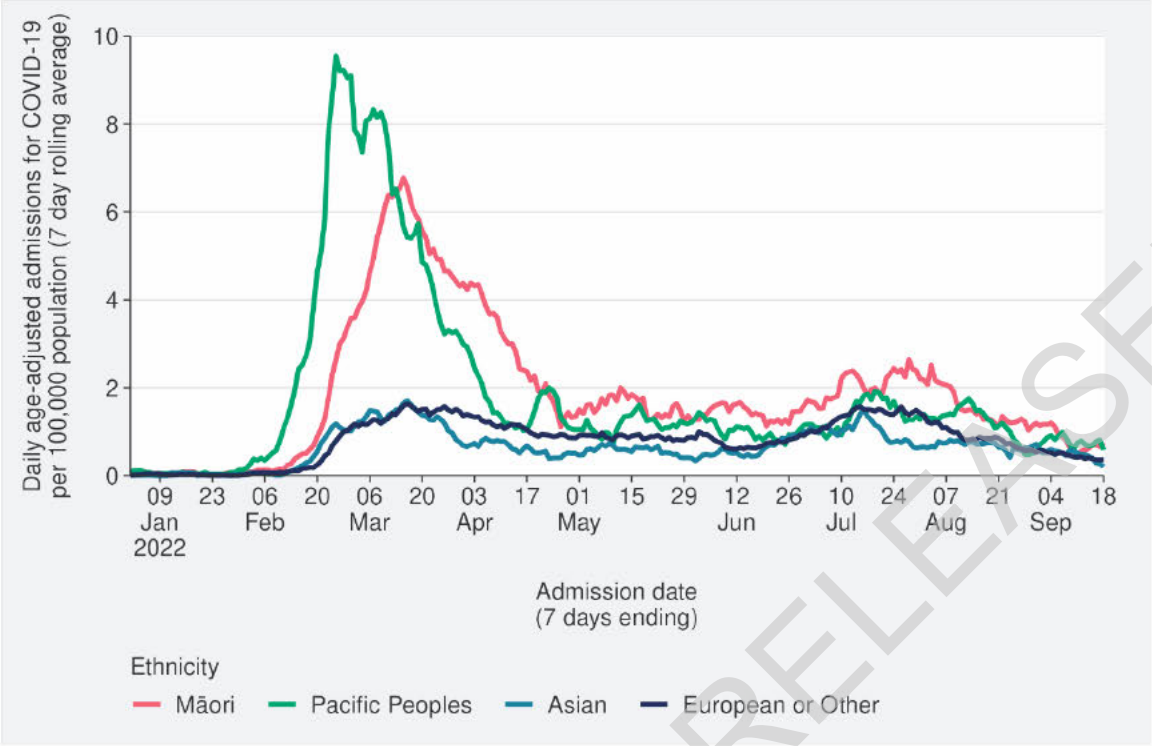
Hospitalisation rates

Analysis undertaken to assess hospitalisation risk from COVID-19 has found that disparities in hospitalisation risk by ethnicity, deprivation and vaccination are clearly observed after adjusting (age-standardising) for differences in age demographics.

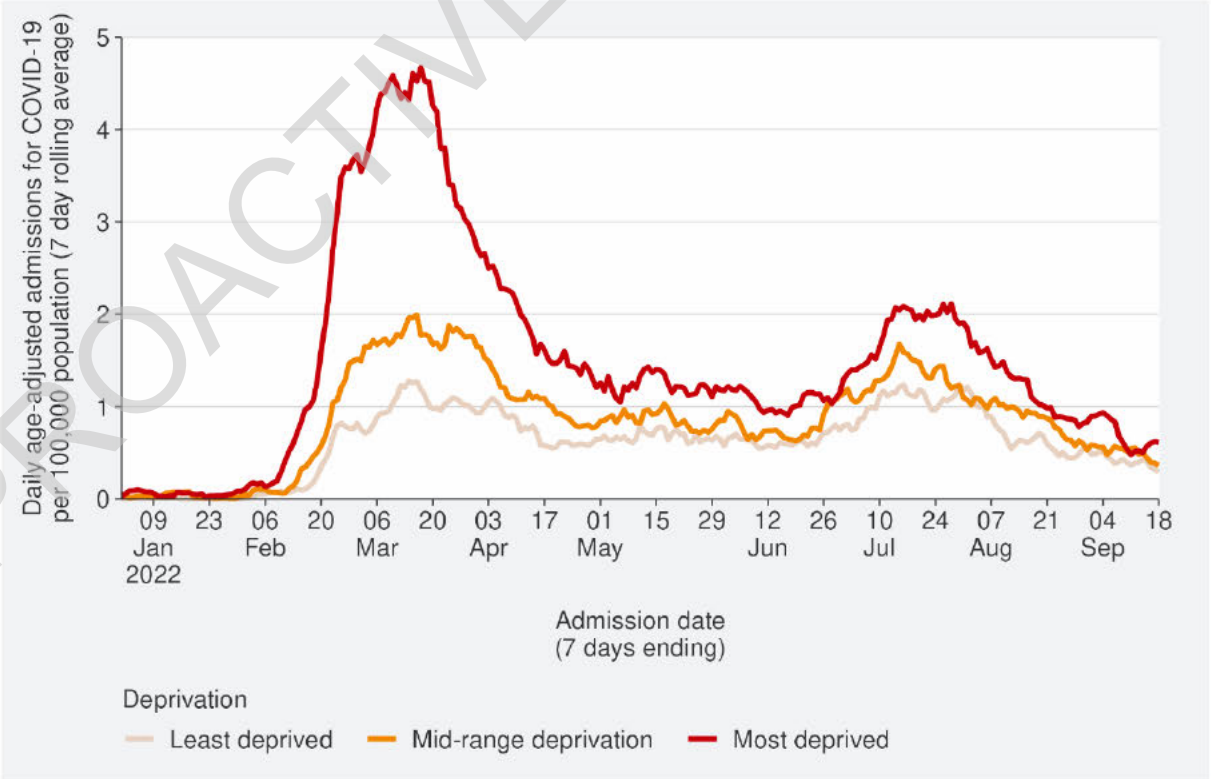
The age-standardised Māori cumulative hospitalisation rate for COVID-19 is 2.1 times higher than European or Other. Pacific Peoples had the highest cumulative incidence rate of hospitalisation with COVID-19, which was 2.8 European or Other ethnicity. (see Figure 3 below).

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

Figure 3 - Age-standardised cumulative incidence of hospitalisation with COVID-19 by ethnicity, January 2022 to 18 September 2022



Similarly, those most deprived communities have had, and continue to have, the highest rates of hospitalisation, both recently and cumulatively during 2022. Those most deprived communities have had 2.1 times the risk of hospitalisation compared with those who are least deprived.



Mortality rates

As at 9 October, there were 2,055 deaths attributed to COVID-19 in 2022. The weekly number of deaths attributed to COVID-19 has continued to decrease.

The age-standardised cumulative mortality rate for Māori is 2.0 times higher than European or Other. Pacific Peoples have the highest age-standardised cumulative mortality risk of any ethnicity, 2.5 times that of European or other ethnicities.

Targeted protections to address disparities

That is why the baseline measures include targeted protections for the most vulnerable. For example, in the winter package there was expanded access to antivirals, particularly for people at significant risk of adverse health outcomes from COVID-19. These measures included increased availability of medical masks, including to Pacific churches, marae, kaumatua facilities, aged residential care (ARC), and Māori and Pacific vaccination providers.

Increases in the risk of health impacts of COVID-19 could disproportionately affect populations groups such as older people, disabled people, Māori, Pacific peoples, and some ethnic communities.

We have provided more detailed equity analysis in the 'analysing the proposals' section.

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

Given the broad implications of COVID-19 requirements and consistent with the requirements in the COVID-19 Public Health Response Act 2020, we need to consider Public Health Implications, Bill of Rights Act Implications and Te Tiriti o Waitangi and Equity Implications.

Public Health advice:

These proposals are informed by the Public Health Risk Assessment process, and the summary findings from the PHRA are noted in the analysis. The intention in this RIS is not to review the public health analysis, but to consider the other factors that inform the regulatory process.

Bill of Rights Act and other legal implications:

s9(2)(h)

[redacted]

Te Tiriti o Waitangi, and ensuring proposals uphold the following principles:

- Tino rangatiratanga
- Equity
- Active protection
- Options
- Partnership.

Te Tiriti o Waitangi implications and equity implications have been assessed in the 'analysing the proposals' section.

Outline the key assumptions underlying your understanding of the problem.

The overarching issues that have prompted this problem are:

- Changing public health context, where the risk from COVID-19 has reduced at the current time (although we need to remain prepared for future variants of concern).
- Bill of Rights Implications, noting that with the changing public health context and the length of time the measures have been in place, proportionality continues to evolve.
- Following the repeal of the COVID-19 Protection Framework, the current strategic approach is more flexible and better suited to the current context.

What objectives are sought in relation to the policy problem?

We are seeking a response that is consistent with the overall objectives of the strategic approach, and fulfils key health objectives.

The overall objectives are:

- **Prepared** means we are prepared to respond to new variants with appropriate measures when required. This includes having the measures in place, including surveillance, to know when and how we might need to respond.
- **Protective and resilient** means we continue to build resilience into the system, and continue both population and targeted protective measures. We take measures as part of our baseline that reduce the impact on individuals, families, whānau, communities, businesses, and the healthcare system that will make us more resilient to further waves of COVID-19.
- **Stable** means our default approach is to use as few rights and economy limiting measures as possible. As part of our baseline there are no broad-based legal restrictions on people or business, and no fluctuating levels of response to adapt to.

Section 2: Deciding upon an option to address the policy problem

What criteria will be used to compare options to the status quo?

Consistent with the requirements in the COVID-19 Public Health Response Act 2020, and other related requirements, we have identified the following criteria.

Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds Bill of Rights Act 1990 (BORA) considerations (thereby informing the legal basis for the measures considered).

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

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

Compliance- expected public compliance with measures (noting that this would only be used where compliance is relevant- e.g not where there is a mandated requirement to fulfil e.g vaccination for health care workers, or information provision from new arrivals).

These criteria are the aligned to the criteria for the new strategic approach. We note that implementation considerations are being considered separately, in Section 3 below.

What scope will options be considered within?

This is focussed on the reviewing the public health responses to COVID-19 that require COVID-19 specific Orders, as listed in the problem statement.

Analysing the proposals

You will find the proposals for different options for each of the measures considered below. This is then supported by analysis, including public health advice and multi-criteria assessment.

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

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

1. Provision of information by air arrivals for COVID-19 contact tracing

Options

Option 1: Status-quo – mandatory collection through NZTD	Option 2: No mandatory collection through NZTD
Retain the current mandatory requirement, under the COVID-19 Public Health Response (Air Border) Order 2021, for arrivals to New Zealand to provide contact details and travel history information to assist potential future contact tracing.	Remove the requirement and, if and when necessary, stand-up digital collection through NZTD and in the interim use scanned paper information.

Public Health Risk Assessment recommendation

PHRA recommendation	Remove the requirement on the basis that it is no longer proportionate in the current phase of the pandemic: • it is unlikely that contact tracing will be effective in responding to the most likely next serious variant of concern (high transmissibility and low severity) • if contact tracing were required, digital collection through NZTD could be stood up again if and when necessary.

Multi-criteria assessment

Criteria	Option 1: Status quo – mandatory collection through NZTD	Option 2: No mandatory collection through NZTD

Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds BORA considerations	+/- • This mandatory measure was seen as proportionate earlier in the pandemic on the basis that it involved a minor imposition on people returning to New Zealand, relative to the benefit of enabling more timely contact tracing in the event of a new variant of concern.	+ In the current situation: • Contact tracing is likely to be of limited value in response to a serious new variant of concern given the absence of other restrictive measures. • Scenario planning has determined that contact tracing will not be effective in the context of a new variant of concern.
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- Costs include: • for travellers, the time and inconvenience cost for them (pre-flight, or post-arrival) in providing some information twice (on the arrival card and through NZTD). • for border staff, the costs include the impacts of delays in processing flights when the paper form of NZTD must be completed by passengers on arrival.	+ While difficult to estimate, the reduced costs are estimated at: • for travellers the reduction in costs might be of the order of $2.8 million per month (on the basis of 12,000 travellers per day, 20 minutes to complete declaration, and an opportunity cost of traveller time at $25/hour). • reduced government expenditure on this measure.
Equity- Evidence of the impacts of the measures for at risk populations	+/- The equity impact of the measure can be considered in relation to: • immediate impacts of collecting the information - depending on relative disadvantage in respect of internet access or language challenges, they may be inequitably affected by this measure (time	+/- • If the measure were removed, the equity impact on at-risk populations could be neutral or very slightly positive. To the extent that at-risk populations have a relative disadvantage in respect of internet access or language challenges, they may be inequitably affected by this measure (time completing NZTD; need to do paper NZTD on arrival).

	completing NZTD; need to do paper NZTD on arrival). • potential future benefits from the use of the information – contact tracing is likely to only have limited effectiveness in the context of a new variant of concern.	
Compliance- expected public compliance with measures	+/- • Under this option to date a high level of overall compliance (digital or paper completion) with NZTD has been achieved (at least 90% digital).	+ • Under this option, there is no NZTD requirement travellers must comply with. Not imposing additional or unnecessary compliance costs on travellers now may help to maintain social licence that is likely important if future restrictions or requirements need to be imposed at the border.
Overall	+/-	+ • The mandatory collection of information through NZTD is no longer proportionate from a public health perspective. Contact tracing in isolation is unlikely to be an effective measure in responding to the most likely serious new variants. • However, there are non-health related reasons for maintain the NZTD. As such, the NZTD will (from 5 November) be enabled by rules under section 421(1) of the Customs and Excise Act 2018 for wider border purposes. If contact tracing of air passengers arrivals for COVID-19 is desired in future, passenger information could be

		accessed from the NZ Customs Service under provisions in the Health Act 1956

The 7-day case isolation requirement

Counter-factual and proposal

Option 1	Option 2
Status quo: the 7-day case isolation requirement remains in place to support the ongoing effective isolation of cases, to prevent spreading COVID-19 outside the household.	Remove mandatory 7-day self-isolation for cases and replace with guidance

Public Health Risk Assessment

PHRA recommendation	Maintain the current 7-day COVID-19 case isolation requirement, at this time. Isolation of infectious cases to reduce community transmission remains an important way to suppress transmission of COVID-19 and subsequently higher numbers of cases, hospitalisations, and deaths. It is likely that the increase in community cases would affect some communities and population groups more than others. Strong concern was expressed that if the isolation mandate was removed, it would have disproportionate impacts for Māori and Pacific communities.

Multi-criteria assessment

Criteria	Option 1: (Status quo) retain 7-day self-isolation requirements for cases	Option 2: removing mandatory self-isolation for cases
Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds BORA considerations	+/- • Isolation of infectious cases to reduce community transmission remains an important way to suppress transmission of COVID-19, and prevent prolonging the current outbreak. • s9(2)(h) [redacted]	- • This approach for cases is likely to lead to subsequently higher numbers of cases, hospitalisations, and deaths and potentially a more pro-longed outbreak. • s9(2)(h) [redacted]

	s9(2)(h) [redacted]	s9(2)(h) [redacted]
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- • The ongoing use of self-isolation is likely to maintain current levels of self-isolation days, however if this is removed it would need to be traded off against the negative health impacts. • The economic impact of CPF Orange was estimated at 1%-2% of GDP in aggregate, $105m per week, with the most significant impact being from self-isolation. • There are wider impacts that are felt across education, health, and other critical services, and on wider society. It's important to note that these impacts will decrease as overall case numbers decrease.	
Equity- Evidence of the impacts of the measures for at risk populations	+/- • Maintaining these requirements reduces potential cases, hospitalisations and deaths, particularly for communities who are at greater risk.	- • s9(2)(g)(i) [redacted] . s9(2)(f)(iv) [redacted] • Coercion to return to work particularly for the most vulnerable. Strong concern was expressed that if the isolation mandate was removed, employees may be pressured to return to work even if not fully recovered.
Compliance- expected public compliance with measures	+/- • While it remains a requirement, compliance is likely to be higher.	- • Moving away from a compulsory requirement is likely to decrease the level of compliance. • Accurate domestic data on the behavioural impact of shifting from mandatory isolation to

		guidance is lacking. However, data from the UK infection survey (based on adherence rates to guidance in the UK) suggests potentially larger increases in cases and hospitalisations from such a change.
Overall	+/- • Given the potential public health impacts, this remains effective, justifiable and proportionate at this time. It will be critical that this remains under regular review.	- • Moving away from this approach at this time is likely to increase the public health risk and resulting impacts.

Point of care testing

Counter-factual and proposal

Option 1	Option 2
Status quo: retain the current framework (regulating the importation, manufacture, supply, sale, packaging or use of point of care tests by Order)	Remove the current framework but rely on baseline (non-COVID-19 specific) regulation, guidance and government procurement

Public Health Risk Assessment

PHRA recommendation	It is appropriate to maintain the regulation of point of care testing, so long as mandatory self-isolation requirements remain in place.

Multi-criteria assessment

Criteria	Option 1: (Status quo) retain the current framework	Option 2: removing the current framework
Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds BORA considerations	+/- • The results obtained from POCTs inform COVID-19 policy and response measures. Ensuring devices can detect the virus, especially as variants evolve, helps to ensure that our system-wide response to COVID-19 is appropriate	- • Under this option, there would be no prohibition on the dealing, importation, manufacture, or use of point of care tests. Only government-distributed and procured devices would undergo a formal approvals process. • This could result in less-reliable and less-accurate devices being available on the market
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- • As with the removal of any regulatory process, some commercial parties may perceive inequities of having borne compliance costs in seeking approvals where that is no longer required for new market entrants. There may also be a perception from the public that the previously strict approvals process was a burden that was ultimately not required	
Equity- Evidence of the impacts of the measures for at risk populations	+/- • The purpose of this Order is to ensure that point of care tests that are relied upon to establish whether a person is subject to mandatory self-isolation requirements are accurate and reliable.	- • Removing this Order could result in more false-positive cases and more false-negatives. The net impact would be increased risk to at risk populations (due to false negatives) and more people being forced to isolate without justification (false positives)
Compliance- expected public compliance with measures	+/-	-

	• People are more likely to use point of care tests if they are perceived as being reliable and accurate.	• Removing this Order could result in less-accurate and less-reliable point of care test being on the market. People are therefore less likely to be compliant.
Overall	+/- • Point of care tests remain the dominant form of COVID-19 testing in New Zealand by a substantial margin. Most people who need to test for COVID-19 will do so first through a point of care test. It is therefore desirable that the Government has a proactive involvement in ensuring these devices are safe and reliable.	- • Moving away from this approach at this time is likely to increase the public health risk and resulting impacts.

Mask settings

Options

Option 1 (PHRA Proposal)	Option 2
Retain current mask requirements in healthcare settings (including aged residential care)	Remove the mask requirement and provide guidance to health services to set masks policies

Public Health Risk Assessment

PHRA recommendation	Retain the current requirement mask requirements. While adherence to mask requirements may be waning or patchy in some health service settings, it is possible that adherence would drop further if the mandate was removed. Mask requirements lean against inequity, to ensure that people who are at higher risk can access health services without avoidable additional risk. Removing mask mandates in health service settings may lead to an increase in cases of hospital-acquired COVID-19.

Multi-criteria analysis

Criteria	Option 1 (status quo): Mask requirements in healthcare settings	Option 2: Remove the mask requirement and provide guidance to health services
Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds BORA considerations	o • s9(2)(h) [redacted]	+ • s9(2)(h) [redacted]
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- • Aggregate economic impact of stepping down mask mandates relative to the status quo is relatively small, particularly as guidance will be communicated and some level of compliance is retained.	
Equity- Evidence of the impacts of the measures for at risk populations	o • Current mask use provides effective protection for vulnerable populations.	+/- • Relative to the status quo, notwithstanding the uncertainty around compliance, the intent is for masks to be mandated in relatively similar

		settings, with the objective of protecting at risk populations.
Compliance- expected public compliance with measures	o • While there were challenges with the introduction of the masks requirement, the principle of "stability" suggests retaining the current approach now it is established. • Changes would require communications to health services in implementing masks policies.	+/- • Challenges have been experienced – both in terms of communications and operationally – to implement the status quo through a single mechanism for requiring masks for staff and patients, and another mechanism for visitors. • A key success criterion for this option will be communicating the policy clearly.
Overall	o	+

Equity analysis

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

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

Reducing mandated public health measures may lessen the impact of public health measures on choice, economic stability and experience of inequity due to enforcement systems. However, it has the potential to increase the inequity associated with co-morbidities or other health conditions that exacerbate the effect of contracting the virus, for example leading to self-imposed isolation, or an increased chance of hospitalisation or needing medical intervention. Removing measures such as border measures that are not expected to affect the burden on the health system overall may result in the burden being transferred to and disproportionately experienced by priority populations.

An initial assessment of impacts and opportunities of the new strategy for priority populations is set out below.

Due to time constraints, further comprehensive consultation has not been completed with Māori and Pacific Peoples to inform the equity analysis. The new strategy will allow us to be more adaptable and target measures to the most vulnerable communities (e.g., strengthened guidance on testing in highly vulnerable places). It is important that consultation on the proposed changes is carried out to identify the potential impacts on these groups and mitigations. Given that, any stepping down of mandatory measures will need to be accompanied by close monitoring of how the changes impact vulnerable populations.

Equity analysis for Māori

The COVID-19 outbreak has worsened already inequitable health outcomes experienced by Māori. The mandatory measures in place have sought to minimise and protect priority populations from COVID-19. As measures are stepped down, the Manatū Hauora Māori Protection Plan is critical. The plan, due to expire in December 2022, focuses on:

- protecting whānau, hapū, iwi and hapori Māori from the virus by increasing vaccination coverage
- building the resilience of Māori health and disability service providers and Māori whānau, hapū, iwi and hapori Māori to respond to the new environment of the Delta variant, the COVID-19 Protection Framework and the long tail of the impact of COVID-19 on the health and wellbeing of Māori.

For Māori, 86.8 percent of people are at least partially vaccinated and 56.3 percent of Māori eligible for first boosters have received them. While there are high vaccination rates for at least one dose, booster vaccination uptake could be improved among Māori. Particular

consideration of accessibility to tools that prevent risks of transmission or severe disease will be considered for iwi; an example of this is the increased availability of medical masks to marae, kaumatua facilities, and Māori vaccination providers.

Equity analysis for Pacific peoples

Pacific Peoples continue to be disproportionately affected by COVID-19 in addition to long-standing inequitable health outcomes and service use. Recent data shows Pacific Peoples are the demographic most hospitalised for COVID-19 and their COVID-19 mortality rate is four times greater than European or other ethnicities.

91.7 percent of Pacific peoples are at least partially vaccinated (compared to 91.5 percent across all ethnicities) and 61.2 percent of eligible Pacific peoples have received at least one booster dose (compared to 73.1 percent across all ethnicities). There is more work to be done in encouraging booster vaccination uptake among Pacific peoples to mitigate the impact of removing mandatory measures.

Equity analysis for older people

Older people are more likely to be hospitalised and this is reflected in the latest data. As the virus takes longer to move through this population due to this group having fewer social interactions, it may lead to a higher hospitalisation burden over a longer period beyond winter. Removing mask requirements will have an impact amongst this group.

Equity analysis for disabled people and tāngata whaikaha Māori

The Human Rights Commission's report Inquiry into the Support of Disabled People and Whanau during Omicron found that lessening restrictions led some disabled people to choose to isolate themselves, leading to feelings of isolation and stress and a restriction on their own freedoms for the benefits of others. The continuation of measures, particularly face masks when accessing essential services, creates reassurance. Changes to these requirements in the future are likely to cause greater anxiety and risk for disabled people, particularly those with underlying co-morbidities.

Without data disaggregated by disability, determining impacts of variants of concern or public health measures on disabled people and tāngata whaikaha Māori would be difficult.

Equity analysis for other groups

Those who live in crowded housing, especially Māori, Pacific peoples, and some ethnic communities for example, living in an intergenerational arrangement, or those who work in particular roles such as hospitality or retail, are also likely to be more at risk of transmission.

Removing the requirement for household contacts to self-isolate would reduce disruption in the education sector for children, young people, and education workers, and enable tertiary education providers to continue delivering services which have been challenged by staff shortages. More learners will be able to access in-person learning.

Te Tiriti analysis

Demonstrating a commitment to and embedding the Te Tiriti and achieving Māori health equity remain a key COVID-19 health response priority. The COVID-19 outbreak has worsened the already inequitable health outcomes for Māori.

In December 2021, the Waitangi Tribunal's Haumaru: COVID-19 Priority Report found that the Government's rapid transition into the CPF breached Te Tiriti principles of active protection, equity, tino rangatiratanga, partnership and options. The Crown would remain in active breach

until the Waitangi Tribunal recommendations were addressed or if a similar rapid shift from the CPF's mandated measures occur.

Following the revocation of the CPF and the changes proposed following the latest PHRA, the Māori Protection Plan's two key drivers are critical. Related response initiatives should continue to have a positive impact for Māori, including the ongoing Winter Package measures. This includes as free medical and N95 masks, greater access to antivirals for those that are eligible by prioritising equitable access for Māori alongside other eligibility criteria, and COVID-19 and flu vaccinations. However, a future PHRA may need to further consider measures to assist Māori if infection rates and hospitalisations do not improve in the interim.

In DPMC's discussions with NICF members about stepping down mandatory measures, they were concerned about tino rangatiratanga, particularly over marae – i.e., marae should be empowered to manage the welfare of their people rather than having requirements externally mandated. The suggestion was to replace it with accessible guidance on best practice and continued communications to address the complacency and misinformation some NICF members are observing. NICF members have also observed the hardship that requiring household contacts to isolate placed on many whānau, and that there will be some support for the removal of this requirement.

Measures targeted at Māori continue to be necessary but have not been sufficient alone to create equitable health outcomes for Māori. We need to identify targeted measures and public health levers that will enable the Crown to meet its obligations under Te Tiriti o Waitangi and help reduce inequities in COVID-19 effects. The work of Te Aka Whai Ora with Kaupapa Māori providers is particularly key to realising this duty. NICF members and disability sector representatives reinforced the value of Kaupapa Māori providers in reducing inequities as they provided holistic support for whānau and had deeper reach than other providers.

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

Based on an overall assessment, the recommendations are to

a. remove the requirement to provide information by air arrivals for COVID-19 contact tracing
b. retain mandatory self-isolation of cases
c. retain point of care tests regulation
d. remove and replace masks requirements in healthcare settings (including aged residential care) with guidance for health services to set masks policies.

Section 3: Delivering an option

How will the new arrangements be implemented?

The proposals in this paper require amendments to Orders made under the Act. Specifically:

- Revoking the Air Border Order – as the mandatory collection of traveller information through NZTD is the last remaining substantive health requirement in the COVID-19 Public Health Response (Air Border) Order 2021, the Order should now be revoked. The timing of revocation should allow for any operational implementation considerations.
- If the Government decides to move to guidance for health services to set masks policies, then the COVID-19 Public Health Response (Masks) Order 2022 can also be revoked.

There are no changes proposed to the remaining Orders under the Act, being the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022; and the COVID-19 Public Health Response (Point-of-care Tests) Order 2021.

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

For the most part, where further measures are required to support ongoing adherence to public health advice or where additional surveillance is required, this is already in place. Work is progressing on the development of communications for new arrivals, and the additional surveillance required is already in place.

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

Planning for new variants of concern has been prepared through the COVID-19 Variants of Concern Strategic Framework. Work is currently well advanced with DPMC and other agencies to ensure that we have the legal framework, and we are operationally prepared to respond as needed in the future. Any future changes would be subject to further Public Health Risk Assessments.

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

The public health measures will remain under regular monitoring and review, this includes monitoring of case numbers, hospitalisations, international trends to identify variants of concern, along with wastewater and other surveillance activities. Trends in case numbers, hospitalisations and mortalities are compared by ethnicity and deprivation. The results of this monitoring and surveillance is compiled into a weekly insights report (as well as other ad hoc reporting) to help inform decision making.

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

Development is underway of both a COVID-19 infection prevalence survey and a COVID-19 seroprevalence survey. The surveys provide an opportunity to establish a national active surveillance initiative within New Zealand, gathering useful evidence to support short- and medium-term pandemic management and planning, and with potential to be adapted for other public health surveillance requirements in the future.