Briefing for decision

Self-repeal of the COVID-19 Public Health Response Act 2020 – draft Cabinet paper

Date due to MO:	20 September 2024	**Action required by:**	24 September 2024
Security level:	IN CONFIDENCE	**Health Report number:**	H2024051395
To:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☒		
Proactive release:	The **title** of this briefing is proposed for proactive release ☒		

Contact for telephone discussion

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

Minister's office to complete:

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☐ See Minister's Notes	☐ Withdrawn	

Comment:

Self-repeal of the COVID-19 Public Health Response Act 2020 – draft Cabinet paper

Security level:	IN CONFIDENCE	**Date:**	20 September 2024
To:	Hon Dr Shane Reti, Minister of Health		

Purpose

1 As requested, this paper provides you with a draft Cabinet paper for Ministerial consultation that:

a. seeks Cabinet agreement to allow the COVID-19 Public Health Response Act 2020 (the COVID-19 Act) to self-repeal on 26 November 2024

b. updates Cabinet on work underway to modernise legal provisions for the management of pandemics and infectious diseases.

Background

2 In May 2024, the Ministry of Health (the Ministry) provided you with a briefing seeking your decision on whether to let the COVID-19 Act self-repeal on its sunset date of 26 November 2024 (H2024040017 refers). It also provided options to address issues identified with the broader pandemic-related legislation.

3 You decided to make the minimum changes necessary to the Health Act 1956 to address known issues and improve its functionality. The Ministry provided you with policy proposals to give effect to these minimum changes in June 2024 (H2024042871 refers). Subsequently, you decided that these policy proposals could be passed under urgency should an imminent pandemic or significant disease outbreak occur, and that in the meantime the Ministry should progress a broader pandemic legislation review.

4 In August 2024, you requested a paper, seeking Cabinet agreement to allow the COVID-19 Act to self-repeal, and to provide an update on work underway to address known issues with pandemic-related legislation.

A draft Cabinet paper is attached

5 The attached paper:

a. advises that the epidemiological risk profile of COVID-19 is such that the likelihood of a deterioration of the COVID-19 situation to a point where the return of mandatory measures is required, is very low

b. seeks Cabinet agreement to let the COVID-19 Act self-repeal on 26 November 2024 on its sunset date

c. notes that Health New Zealand can manage a deterioration in the COVID-19 situation through enhanced non-mandatory public health measures

d. outlines issues with the broader pandemic related legislative framework and advises that the Ministry is undertaking a legislative review

e. notes the Ministry has provided you with a set of limited policy proposals to amend the Health Act 1956, that could be passed under urgency if required due to an emergency response, prior to the Ministry's broader legislative review being complete

f. seeks agreement that you report back by June 2025 with policy options to address the issues identified.

6 The Ministry has consulted with Health New Zealand and relevant government agencies. Health New Zealand, and other agencies that expressed a view are supportive of the proposals.

Equity

7 The self-repeal of the COVID-19 Act will have minimal equity implications because there are no orders currently in place. The review underway of the broader pandemic legislation will consider the impact on disadvantaged groups.

Next steps and suggested timeframe

8 The paper is scheduled to go to Cabinet on 21 October 2024. If you approve the draft paper the key timeframes are set out below.

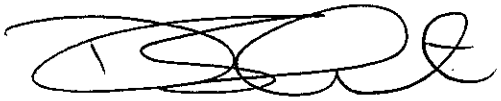
Table 1: Key timeframes for the draft Cabinet paper on self-repeal of the COVID-19 Act

20 September – 24 September	Provide any feedback on the attached Cabinet paper for the Ministry
25 September – 8 October	Ministerial consultation on the paper
9 October	Final paper provided to you
10 October	Paper lodged with Cabinet Office
16 October	Cabinet Social Outcomes Committee consideration
21 October	Cabinet consideration

Recommendations

We recommend you:

a) **Approve** the draft Cabinet paper for Ministerial consultation. **Yes/No**



Dr Diana Sarfati
Director-General of Health
Te Tumu Whakarae mō te Hauora
Date: 18/9/24

Hon Dr Shane Reti
Minister of Health
Date:

Minister's Notes

MANATŪ HAUORA
MINISTRY OF HEALTH

Briefing

Health system pandemic preparedness: options for legislative reform

Date due to MO:	3 May 2024	**Action required by:**	10 May 2024
Security level:	IN CONFIDENCE	**Health Report number:**	H2024040017
To:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☒		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, Strategy, Policy and Legislation	s 9(2)(a) [redacted]
Dr Andrew Old	Deputy Director-General, Public Health Agency	

Minister's office to complete:

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

Comment:

Health system pandemic preparedness: options for legislative reform

Security level:	IN CONFIDENCE	**Date:**	3 May 2024
To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. On 14 April 2024, you agreed to an integrated pandemic preparedness work programme that incorporates both ongoing and new pandemic-related activities, including a review of pandemic-related legislation [refer H2024036792].
2. This briefing:
   a. provides an overview of work undertaken to date to review pandemic legislation
   b. seeks your decision on whether to develop a new legislative framework for pandemic response and management
   c. seeks your decision on whether to extend the COVID-19 Public Health Response Act 2020 that will otherwise automatically self-repeal on 26 November 2024.

Summary

3. The COVID-19 response demonstrated that it is possible to have a high degree of social license for, and voluntary compliance with, public health measures where those measures are necessary, proportionate, science-based, well-communicated, and widely understood.
4. A robust legal basis for public health measures is necessary when the population-wide consequences of non-compliance are high, and also to provide transparency and consistency in the application of measures. A legal framework ensures that significant decisions are taken by elected officials and subject to public accountability and scrutiny through parliament.
5. COVID-19 has highlighted shortcomings in New Zealand's existing legislative framework for pandemic management. The powers in the Health Act 1956 (the Health Act) and the Epidemic Preparedness Act 2006 provided for New Zealand's early response to COVID-19 but were not fit-for-purpose to support a sustained Government response. Court decisions during the COVID-19 response have also highlighted weaknesses in certain Health Act provisions. As a result, decision-makers currently have more limited options to manage the next pandemic than were believed to be available before COVID-19.
6. The Ministry of Health (the Ministry) has developed options for a review of the pandemic legislative framework that could update and make fit-for-purpose legislation relating to pandemic response and management. The status quo – leaving the legislation as it currently stands – is also an option, although there are risks to this approach as outlined in this briefing. Subject to your decision, officials could report back to you in October with policy proposals to inform a new pandemic Bill.

7. The COVID-19 Public Health Response Act 2020 (the COVID-19 Act) was developed and passed under urgency in May 2020 to provide the legal basis for most of the COVID-19 response.

8. While the COVID-19 Act illustrates some good legislative design to manage the use of exceptional powers in a pandemic, it can only be used to respond to COVID-19. The COVID-19 Act is also due to self-repeal on 26 November 2024. If the Act is not extended, it will not be legally possible to make COVID-19 Orders in the future, should this be required to respond to a deterioration in the COVID-19 situation. The most notable measures that would no longer be supported in this situation are broad based mask requirements and the isolation of COVID-19 cases.

9. To be able to potentially use Orders-based measures to manage future waves of COVID-19, there is an option to extend the COVID-19 Act. This option would require you to take proposals to extend the COVID-19 Act to Cabinet in early June.

Recommendations

We recommend you:

a) **Note** that New Zealand's response to the COVID-19 pandemic has highlighted limitations with the existing legislative framework for managing pandemics

b) **Note** that the Government's ability to appropriately manage a pandemic in the future depends on a fit-for-purpose legislative framework

c) **Note** that not addressing the issues with legislation could result in the need for rapid bespoke legislation to be developed in the event of another pandemic

d) **Note** that the Ministry of Health (the Ministry) has identified 3 options, in addition to the status quo, to reform the legislative framework for managing pandemics

e) **Agree** that the Ministry proceed with EITHER:

i.	Status quo - retain the existing legislative framework for responding to pandemics, OR	**Yes/No**
ii.	Option A – minimum change necessary to address known issues and improve the functionality of the Health Act 1956, OR	**Yes/No**
iii.	Option B – targeted review of the health system aspects of pandemic response legislation, OR	**Yes/No**
iv.	Option C – wide-ranging all-of-government review of pandemic response provisions in all relevant legislation.	**Yes/No**

f) **Note** that the indicative timeframes for pandemic legislative reform could enable the Government to progress legislative recommendations from the Royal Commission of Inquiry on COVID-19 Lessons Learned report (currently due to report by 30 September 2024)

g) **Note** that, subject to your decision, the Ministry could provide you with advice on the policy proposals for pandemic legislative reform in October 2024

h) **Note** that the COVID-19 Public Health Response Act 2020 (the COVID-19 Act) is currently set to self-repeal on 26 November 2024

i) **Note** that if the COVID-19 Act self-repeals, the immediate gap would be that case isolation and mask requirements could no longer be legally mandated if the situation required it in the future

j) **Note** that extending the COVID-19 Act would require an amendment Bill to be introduced and passed by the House before 26 November

k) **Agree** to EITHER:

i. take no action and allow the COVID-19 Act to self-repeal on 26 November 2024, OR **Yes/No**

ii. take a paper to Cabinet in early June proposing that the COVID-19 Act is extended to allow future pandemic legislation to be developed and enacted, and seeking agreement to issue drafting instructions to the Parliamentary Counsel Office for a Bill to affect this change. **Yes/No**

l) **Indicate** if you would like to discuss the matters in this briefing further with officials. **Yes/No**

Maree Roberts
Deputy Director-General
Strategy, Policy and Legislation
Date: 3 May 2024

Hon Dr Shane Reti
Minister of Health
Date: 9/5/2024

Health system pandemic preparedness: Legislation

Background

1. While COVID-19 has been the most significant global pandemic in 100 years, there have been a number of 'near-misses' as well as a mild pandemic of influenza H1N1 in 2009/10. The risk of a new pandemic remains[1], emphasising the need to maintain readiness and resilience.

2. Many potential pandemic scenarios involve uncertainty and incomplete information about the infectious disease, its pathology, and the tools that may be needed to respond to an outbreak. The COVID-19 response demonstrated the need for different strategies, at different times, reflecting the context. A range of public health measures were used to deliver these strategies, including as new measures became available (eg vaccines).

Part 1: Review of pandemic legislation

Legislation strengthens the basis for health measures

3. The COVID-19 response demonstrated that a high degree of social license for, and voluntary compliance with, measures is essential to achieve desired health outcomes.

4. However, a legal backstop for health measures is required:

   a. in circumstances where the population wide consequences of non-compliance are high (behavioural science suggests that more people will comply with a mandatory requirement, even if the risk of enforcement is low)

   b. to demonstrate that rights-limiting measures are necessary and proportionate

   c. to raise significant decisions to Ministers/Government and provide public accountability and scrutiny through Parliament

   d. to ensure transparent decision-making and implementation enabling judicial review through the Courts

   e. to provide consistency in their application of measures (eg with no discretion, interpretation or local variation).

New Zealand's current legislative framework for managing pandemics is dispersed...

5. New Zealand's legislative framework for managing epidemics and pandemics is principally contained within 3 pieces of primary legislation:

[1] Te Niwha's research (Likely future pandemic agents and scenarios, 2023) suggests that potential pandemics can include:

- Infectious diseases with well-established pandemic potential (eg. influenza in 1918, 1959 and 2009)
- Emerging infectious diseases with pandemic potential (eg. SARS 2002, MERS-CoV 2012, COVID-19 2020, Ebola 2014 and Mpox 2022)
- Well characterised infectious diseases with reintroduction potential (eg. Diphtheria 1998, Polio 2014 and Measles)
- Exotic vector-borne and zoonotic infectious diseases with high introduction potential (eg. arboviral diseases including Zika 2016, Dengue, Chikungunya).

a. the Health Act 1956 – contains emergency and non-emergency legislative powers to respond to, and manage, infectious and notifiable diseases. A list of notifiable diseases is outlined in Schedules 1 and 2 of the Act

b. the Epidemic Preparedness Act 2006 – enables the Prime Minister to create an Epidemic Notice where an outbreak of a quarantinable disease is likely to significantly disrupt essential government and business activity. The Epidemic Notice triggers powers in other legislation to support an epidemic response

c. the COVID-19 Public Health Response Act 2020 – provides for the relevant Minister to make legal Orders to support the management of COVID-19.

... and the current legislative framework is not optimal for supporting a pandemic response

6. The response to the COVID-19 pandemic, and the testing of legal instruments through the courts has highlighted some issues with these Acts. As part of the Ministry's work to use knowledge gained from the COVID-19 experience and enhance our preparedness for future pandemics, we are reviewing New Zealand's pandemic legislation to ensure it is fit for purpose.

Issues with the Health Act

7. The primary issue is that following the Borrowdale Judgment, the Health Act's section 70 powers have been found to be more limited than previously thought.

8. s 9(2)(h)

9. [redacted]

10. Other issues with the Health Act 1956 include:

a. The powers in sections 70 and 71 are blunt in nature. For example, a business could be ordered to close, but no mitigation measures could be implemented such as allowing a business to open with capacity limits, which allow a more nuanced approach to risk-minimisation measures. Other nuanced measures such as mask use and case isolation requirements could also not be introduced under the Health Act.

b. Sections 70 and 71 also lack the safeguards typically in place for emergency powers and provide for unelected officials to exercise extraordinary powers. The law should reflect modern democratic processes and include ministerial oversight of legal powers which may have material impact on people's rights.

c. Part 4 of the Act is critical for border controls, but it is outdated and no longer fit-for-purpose. Some provisions are very ambiguous, such as health clearance for arriving craft and liability to quarantine, and they have been challenging to operationalise.

11. While the provisions in the Health Act proved insufficient for the sustained response to COVID-19, they have been successfully used by Medical Officers of Health to manage local outbreaks of contagious diseases, such as measles. Reviewing the emergency powers in the Health Act provides the opportunity to consider where the boundaries should be between powers exercised by Medical Officers of Health, powers exercised by the Director of Public Health, and powers exercised by Ministers.

Issues with the Epidemic Preparedness Act

12. The COVID-19 response also demonstrated that aspects of the Epidemic Preparedness Act 2006 were not fit-for-purpose. Briefly, the key issues with the Epidemic Preparedness Act include:

    a. The triggering test for issuing a pandemic notice is too narrowly focused on the disruption of government and business activity – it does not allow for public health considerations; and

    b. The power to modify existing legislative requirements and restrictions to enable compliance during an epidemic has a high threshold, a narrow scope, and only empowers alternative means of compliance (rather than new criteria). At the same time, there are no tests for whether the modification is necessary or proportionate, and no requirement for a review.

Issues with the COVID-19 Public Health Response Act

13. The COVID-19 Public Health Response Act 2020 provided the powers to implement central aspects of the Government's COVID-19 pandemic response. Despite being rapidly developed and passed under urgency, the legislation enabled New Zealand to navigate through the largest pandemic of the last 100 years, which is expanded on from paragraph 21. However, the Act is COVID-19-specific and due to self-repeal in November 2024, and therefore cannot be relied upon to prepare for future pandemic threats.

Rationale for reform of pandemic legislation

14. The issues outlined above would significantly hinder New Zealand's ability to respond to, and manage, a new pandemic. We have the opportunity to use knowledge gained from the COVID-19 response to improve New Zealand's pandemic legislation via a robust and comprehensive process as outlined in this paper.

15. In addition, aligning the legislation with a new pandemic strategic instrument would ensure clarity and consistency in New Zealand's approach and enhance our preparedness for a future pandemic.

16. The Royal Commission of Inquiry for COVID-19 Lessons Learned is currently due to report to the Government in September 2024. The indicative timeline for pandemic legislative reform would enable the Government to respond to any recommendations for legislative change through this process.

Proposed objectives for new pandemic legislation

17. Taking into consideration the identified issues, the wider pandemic preparedness work programme, and your priorities for the health sector, we propose the following objectives for this piece of work:

a. Fit-for purpose – pandemic legislation that enables New Zealand to respond effectively and efficiently to manage future pandemics, by preventing and managing impacts on people, the health system, and the economy

b. Responsive and evidence-based decision-making – pandemic legislation that enables proactive decision-making that is informed by public health advice and other relevant information

c. Transparent with appropriate safeguards – pandemic legislation that is clear, comprehensible, and specific (insofar as possible) in relation to decisions that could be made in future and actions that may be taken, under particular circumstances

d. Equity and proportionality – pandemic legislation that promotes equitable outcomes, provides response pathways proportionate to the level of risk.

Linkages with other Ministry work programmes

18. Pandemic preparedness and response capabilities do not exist in isolation. Rather, they are extensions (in scope, scale, intensity, specificity and duration) of baseline capabilities for the prevention and management of communicable disease, health service delivery, resilience and generic emergency management functions.

19. The pandemic legislation programme will link in with a suite of pandemic preparedness initiatives undertaken by the Ministry [covered in detail in H2024036792], including:

a. development of a disease-agnostic strategic instrument

b. review of the New Zealand Influenza Pandemic Plan and update to become the interim New Zealand Pandemic Plan (to cover other respiratory pathogens)

c. development of the national quarantine capability

d. update of the National Health Emergency Plan (NHEP)

e. development of a Public Health Strategic Plan for Surveillance

f. the Strategic Approach to Health at the Border (SAHB)

g. international negotiations including on the International Health Regulations, a new pandemic treaty, convention or other agreement on pandemic preparedness and response.

Legislative options

20. Three legislative options have been identified that could improve New Zealand's preparedness for future pandemics. The status quo is also an option. A high-level cost-benefit analysis has been undertaken for the purposes of this briefing.

	Description	Benefits	Risks and Impacts	Indicative Timeframe
Status Quo	Retain the existing legislative framework for responding to pandemics.	Would allow Ministry of Health and Parliamentary Counsel Office resources and House / Select Committee time to be allocated to other priorities.	The Courts have determined that the powers in section 70 and 71 of the Health Act are not suitable for managing a long-term health emergency, such as the COVID-19 pandemic. If a new pandemic arrives, urgent work will be needed to enact suitable legislation to respond. This may not allow for timely action to be taken to minimise the spread of a new infectious disease. Or for consultation with the public in advance of rights limited measures being enacted.	N/A
Option A – minimum necessary change to address known issues	The minimum change required to the Health Act to address the issues identified by the Courts, that prevent the Act from managing pandemics at the national level or over the medium to long-term, and the operationally difficult provisions relating to border control. Under this option, sections 70 and 71 of the Health Act would likely be	Restores confidence in using the provisions of the Health Act to respond to new pandemics and addresses issues with the health at the border provisions. The need for bespoke legislation to be made under urgency for predictable aspects of pandemic management is reduced.	Continuing to rely on powers in the Health Act that are very dated (in some cases the provisions are the same as those in place over 100 years ago) presents an ongoing risk for pandemic management in future and a missed opportunity to incorporate lessons from COVID-19. Blending new provisions with old drafting in the Act may impact on	Around 18 months to enactment, depending on legislative priority. A Bill could be ready for introduction later this year. Option B below sets out the general steps required but given the constrained

	Description	Benefits	Risks and Impacts	Indicative Timeframe
	amended to provide a more robust Ministerial authorisation process for the use of national level powers and for the sustained use of regional powers, as well as more explicit reliance on the existing regulation-making powers in Part 6 of the Act to implement Part 3 measures, rather than using notices made by the Director-General and / or Medical Officers of Health. Part 4 would be amended to address critical issues with the provisions that manage health at the border, for example health clearance for arriving craft.		the Act's usability and effectiveness during a response. Relying on regulations made through Order in Council by the Governor-General would be less responsive than the Orders available under the COVID-19 Act. For example, while the Health Act provides for regulations to be made to give effect to quarantine requirements, the COVID-19 response required 27 changes to the legal settings for Isolation and Quarantine between September 2020 when the relevant Order was first made and September 2022 when it was revoked. Regulations could not have provided the flexibility needed in this regard. Unlikely to be able to configure legislation to reflect a new Pandemic Strategy.	nature of the changes under Option A, targeted consultation with affected parties in place of public consultation would be recommended. The public would have the opportunity to engage with the amendments during Select Committee.
Option B - targeted review of the health aspects of pandemic response legislation	A wider review of the provisions in the Health Act, the Epidemic Preparedness Act and the COVID-19 Act relating to the public health response to a pandemic. This option could involve amending Part 3 of the Health Act 1956 to embed COVID-19 Act type provisions	Addresses the issues with the Health Act and the Epidemic Preparedness Act identified during the pandemic (as outlined in this briefing), resulting in fit-for-purpose legislation that would enable the Government to effectively and efficiently respond to a new pandemic threat.	The consequential, transitional, and 'dormant' (until a pandemic arrives) provisions are likely to be complex to develop and implement. However, we have the experience of the COVID-19 pandemic and the COVID-19 Public Health Response Act to draw on.	• Health Report proposing pandemic legislative reform – October 2024 • Policy approval from Cabinet – November 2024

	Description	Benefits	Risks and Impacts	Indicative Timeframe
	and structures (including the changes under Option A) and a two-tier type structure – more limited powers under a Ministerial authorisation and more significant powers only under an Epidemic Notice or State of Emergency. This option would also allow reform of the Epidemic Preparedness Act to better align the triggers and put better criteria and constraints around immediate modification orders and emergency legislative measures. Part 4 could also be amended to ensure the provisions relating to arriving craft and quarantine are fit-for-purpose. Could result in a new pandemic preparedness and response act – replacing the Epidemic Preparedness Act and incorporating COVID-19 Act type provisions into one new Act, replacing Part 3 (possibly 3A) and Part 4 of the Health Act.	Builds on the success of the COVID-19 Act, which was stress-tested during the COVID-19 response to carry forward modern legal provisions for pandemic response. Enables the legislation to be aligned with a new pandemic strategic instrument which would ensure clarity and consistency in New Zealand's approach to future pandemics and reflect the Government's view on appropriate pandemic management. Avoids the need for rapid bespoke legislation to be developed (at a time when the capability and capacity needed to build this legislation are otherwise engaged in responding to a new disease threat). Undertaking a wider review of pandemic response provisions would better allow for the law to be aligned with the government's views on appropriate pandemic management.	While the need for Parliament to pass bespoke legislation in the future is reduced, it can't be ruled out altogether as there will continue to be uncertainty about what the next pandemic will look like and the level of control that may be needed.	• Public consultation – February 2025 • Cabinet approval to issue drafting instructions – April 2025 • Introduction of Bill and referral to Health Committee – August 2025 • Health Committee report-back, Second Reading, Committee of the Whole, and Third Reading – March to May 2026 • Enactment – June 2026
Option C – Wide-ranging all of government review of	A first principles review of all parts of New Zealand's legislation, in addition to the health aspects, that relate to pandemic response and management (including local	Would allow for all aspects of pandemic legislation to be considered across government.	A significant cross-agency project, resulting in a large and complex Bill – the need for which has not yet been established. Pre-determining which aspects of wide-ranging legislation may need	3+ years. A significant amount of policy work would need to be undertaken before a Bill could be

	Description	Benefits	Risks and Impacts	Indicative Timeframe
pandemic response provisions in legislation	government, justice, education, and immigration). This option would extend the review beyond the health sector and include the emergency management system, as well as all urgent / emergency legislation that was put in place as part of the COVID-19 response to enable businesses, local government, and others to manage the immediate impacts of the pandemic response more effectively. Over 40 pieces of legislation, from the Arms Act 1983 to the Waste Minimisation Act 2008 may need to be reviewed.	Ensures consistent all-of-Government planning and input into the legislative framework for pandemic management.	to be amended in advance of a pandemic, and what the changes required might be, would be very challenging and may result in legislation that does not meet our needs. A review of emergency management in New Zealand, with a pandemic focus, may be too narrowly focused given the range of situations in which an emergency can be declared. Public health may become a secondary consideration.	introduced in 2026-27.

Part 2: COVID-19 Public Health Response Act 2020

Background

21. Enacted under urgency on 15 May 2020, the COVID-19 Public Health Response Act 2020 (the Act) enabled the Minister for COVID-19 Response (now the Minister of Health) to make Orders to give legal effect to the public health response to COVID-19.

22. The Orders were a flexible legislative tool that enabled the Government to respond quickly to changing circumstances over the course of the pandemic. Examples of Orders made under the Act include:

    a. vaccination requirements, including the provision of vaccination information and duty to not carry out specified work unless vaccinated, exempt, or authorised

    b. national and regional lockdowns

    c. Managed Isolation and Quarantine (MIQ) requirements

    d. requirements for persons arriving in Aotearoa New Zealand

    e. testing requirements

    f. capacity restrictions

    g. mask requirements

    h. isolation requirements.

23. The Act has been amended a number of times to ensure it remains fit for purpose and is proportionate to the risk of COVID-19 to the public. The Act was amended in November 2022 to extend the expiry of the Act to 26 November 2024 so that Orders relating to mask use in health premises and case isolation would remain active. These measures have since been repealed and there are currently no Orders in force under the Act, although the Act remains active legislation.

Current COVID-19 Context

24. New Zealand has entered a new phase of the COVID-19 response. The impacts of the virus have been reduced by a combination of virus mutation, vaccination, previous infection, public health response measures (greater acceptance of voluntary mask use, covering coughs, testing, hand hygiene, staying home when unwell, etc.), and the availability of antiviral treatments.

25. This, combined with the sacrifices already made by New Zealanders over the last 3 years, suggests the social license for imposing mandatory requirements is unlikely to be as high as it once was in previous stages of the pandemic. This has been demonstrated by Behavioural Surveillance surveys which reported 'pandemic fatigue' has increased over the course of the COVID-19 pandemic and has increased the likelihood that some of the population would not follow public health measures, such as isolation, as closely. In light of this, there would be a high bar for imposing any new Orders under the Act.

26. The future of COVID-19 remains uncertain and variable; unlike many previous pandemics, it does not yet follow seasonal patterns. New variants of SARS-CoV2 continue to emerge, and it remains possible that a substantially more virulent variant may evolve.

27. It is also important to note that COVID-19 is still highly prevalent in the community. There were 2343 cases reported in the week 22-28 April, 159 hospitalisations and 11 deaths, with 2618 cases, 167 hospitalisations and 8 deaths the week prior. The actual number of cases is likely significantly higher given large drops in reporting of COVID-19 infection, and this is supported by wastewater testing and hospitalisation rates.

28. With the fifth wave of COVID-19 in November 2023 to January 2024 being larger than the fourth wave, we know that we cannot necessarily rely on COVID-19 becoming less transmissible or less of an imposition on the health system over time. The World Health Organization considers the pandemic to be ongoing and that COVID-19 will continue to circulate indefinitely and unpredictably.

Ongoing need for legislation

Limitations of the Health Act

29. The COVID-19 Public Health Response Act has been extremely useful in managing the pandemic and in addressing gaps in other legislation, primarily the Health Act.

30. If there was a significant COVID-19 outbreak in the future that required legislative intervention, the provisions available in the Health Act are generic and would not support the implementation of lower-level public health measures to protect against the impacts of COVID-19, such as:

    a. mask use

    b. public health requirements placed on persons entering New Zealand

    c. isolation requirements at a national level or for a sustained period of time.

31. Mask use (in health premises) and case isolation requirements were the final orders to be repealed from the Act in August 2023. If legislative intervention was required to mitigate a significant COVID-19 outbreak in the future, these lower-scale measures would likely be the first measures that might be proposed to be re-introduced.

32. The COVID-19 Public Health Response Act allows more nuancing than the Health Act, for example, the COVID-19 Act allows the precautionary steps listed above to be taken whereas the measures available in the Health Act are more extreme, such as local lockdowns.

33. Further, as noted in paragraphs 18-19, the Borrowdale Judgement on Section 70 Orders has found that Section 70 powers are more limited than first understood.

Public Health Risk

34. Despite the current stage of the pandemic, there is still the potential for a deterioration of our COVID-19 situation due to waning immunity, reduced access to vaccines and antivirals or a new a new variant or sub-variant. A deterioration would likely once again have a greater health impact on older people, Māori, Pacific, people with disabilities and those who are immunocompromised.

35. The COVID-19 Act allows for measures to be ramped up or down in proportion to the level of threat COVID-19 is imposing to public health in order to protect the population and to mitigate significant economic and social effects.

36. Measures may be ramped up through strong guidance to wear a mask and isolate as opposed to mandating these measures via legislation. Given the removal of additional support to isolate, such as sick leave provisions and reduced access to testing from June

2024, strong guidance would be the first approach rather than mandating isolation under these circumstances. However, the COVID-19 Act is the only way to legally implement these measures if legislative intervention was required. Further, the willingness to follow guidance on COVID-19 measures has reduced.

37. To demonstrate the historical importance of case isolation and mask wearing at a point in time where the public health risk justified the imposition of these requirements, 2022 modelling suggested that the removal of mandatory requirements for measures relating to case isolation and mask wearing on 12 September 2022 (and instead relying on guidance) may impact transmission by approximately 20% (this percentage estimated to be 8.5% when these measures were removed).

38. Further to this, it was estimated that if a change in isolation requirements resulted in an increased transmission of 15%, this could cause an 89% increase in peak bed occupancy in our hospitals over the 26 weeks following the change. As a lower-scale example, a 7.5% increase in transmission had been modelled to equate to a 50% increase in peak bed occupancy in hospitals in the two months following the change (requiring around 125-150 additional beds to be occupied compared the status quo settings of 250 to 300 beds required for COVID-19 cases over the same period).

39. It is important to note that broad population level case isolation and mask wearing measures can only be implemented by the COVID-19 Act and could not be mandated at a national level by the Government through the Health Act or any other current legislation, if that Act was repealed. However, making a measure mandatory does not guarantee compliance with it and at this stage of the pandemic the public's acceptance of further restrictions to manage COVID-19 is likely diminished.

Alternatives to extending the Act

40. If the Act was repealed, there would still be the option of 're-introducing' it under urgency if the public health situation required it.

41. This could potentially be achieved in a matter of days. However, in this situation there would be no opportunity for public consultation, which could further undermine the social license for, and compliance with, any mandatory measures.

Other options within the Health Act

42. Part 3A of the Health Act may still be useful in a COVID-19 response. Part 3A would rely on voluntary compliance first, then use powers on a one-on-one basis. If we then required restrictions on specific groups of people or regions, we would then need to use Section 70, which as noted, involves legal risk.

43. Part 3A could only be used as part of a low-level response, not a deteriorating and large-scale outbreak, and the social license for voluntarily complying with preventative measures against COVID-19 is significantly reduced at this point in the pandemic.

Options for the future of the Act

44. We have evaluated two options for the future of the Act:

    a. Option One – Let the Act automatically repeal on 26 November 2024 (Status Quo option)

    b. Option Two – Extend the Act.

Overview of Options for the Future of the COVID-19 Public Health Response Act

Option	Description and Process	Benefits	Risks and Impacts	Timeframes
Option One – Status Quo: Let the Act automatically repeal on 26 November 2024	No action would be required for the automatic repeal.	Allowing the Act to repeal may provide greater certainty about the potential for future restrictions. The public would have the opportunity to have their say on new legal measures, rather than the continuation of the powers in the Act.	The limited powers available in the Health Act would reduce our ability to effectively respond to a COVID-19 resurgence. A key gap would be the availability of lower-scale public health measures such as mask requirements or case isolation requirements that could potentially control a resurgence without the need for the more rights-limiting measures. The repeal of the Act may increase the burden of risk for groups disproportionately affected by COVID-19 as the ability to act early and in a nuanced way would be lost if the Act was repealed. However, a Bill based on the current Act could be re-introduced under urgency if the situation required it.	Act automatically repeals on 26 November 2024.
Option Two: Extend the Act	The Act could be extended either with a set date for repeal should you want to provide certainty about the length of time that	The Act can remain active in the background as a precautionary measure should there be a significant COVID-19 outbreak due to a more virulent or immune evasive variant. It would only be required and justifiably used if	The current state of COVID-19 in New Zealand is low-risk, so therefore it may be considered unnecessary or disproportionate to extend the Act given the current situation and the possibility of re-	Cabinet Paper to the Social Outcomes Committee in June to seek approval for the Ministry to

	powers will continue for, or by removing the self-repeal provision and making the Act open ended should you wish to provide coverage until such time as future pandemic legislation is enacted. An amendment Bill would need to be approved by Cabinet and passed through all Parliamentary stages before the end of November 2024.	legislative intervention was absolutely necessary. This option would best support the legislative implementation of nuanced, lower-level public health measures should they be required in the future, such as mask use, self-isolation requirements and public health requirements for incoming travellers to New Zealand. These measures could not be used under the Health Act. The Act allows measures to be scaled up and down depending on the level of risk, which is a key point of protection for vulnerable populations. Measures available in the Act may help reduce the number of infections of COVID-19 and therefore reduce the costs of hospitalisation, health care costs, welfare costs, and the cost of supporting those with long-term conditions as a result of COVID-19. A healthy workforce also supports a productive workforce.	introducing the Act under urgency if legislative intervention was required in the instance that our first point of action – strong guidance – was ineffective. Setting the extension for a specific date may be more justifiable and appropriate. The legislative tools used throughout COVID-19 have been publicly controversial and the perception of extending the Act indefinitely may not translate well given this. At this stage of the pandemic, compliance with Orders issued under the Act may be diminished.	issue drafting instructions for a Bill to be introduced to the House of Representatives in June or July and undergo a four-month Select Committee process. The amendment Bill would need to be passed before 26 November 2024.

Population Implications

45. The need to proactively address the needs of population groups that experience inequitable health outcomes is a key lesson identified from the response to COVID-19. This includes Māori, Pacific peoples, disabled people, users of mental health services, older people and people with comorbidities.

46. Pandemic legislative reform will assist with preparedness for future pandemics and ensure that the appropriate legal levers are in place to take action and reduce the impact on the health system and vulnerable populations.

Next steps

47. The Ministry will progress further work subject to your decisions on the options presented.

48. The Ministry is available to meet with you to discuss the proposals in this paper in greater detail if you wish.

ENDS.

Aide-Mémoire

Talking points: Self-repeal of the COVID-19 Public Health Response Act 2020

Date due to MO:	11 October 2024	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	H2024053528
To:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☐		

Contact for telephone discussion

Name	Position	Telephone
Emma Hindson	Acting Manager, Public Health Policy and Regulation, Public Health Agency I Te Pou Hauora Tūmatanui	s 9(2)(a) [redacted]
Mark Heffernan	Principal Policy Analyst, Public Health Policy and Regulation, Public Health Agency I Te Pou Hauora Tūmatanui	

Aide-Mémoire

Talking points: Self-repeal of the COVID-19 Public Health Response Act 2020

Date due:	11 October 2024		
To:	Hon Dr Shane Reti, Minister of Health		
Security level:	IN CONFIDENCE	**Health Report number:**	H2024053528

Details of meeting:	16 October 2024, 10.30am
Cabinet Committee:	Cabinet Social Outcomes Committee (SOU)
Purpose of meeting/ proposal:	You are seeking approval from SOU to allow the COVID-19 Public Health Response Act 2020 to self-repeal on 26 November 2024. You are also seeking approval to report-back to Cabinet by June 2025 with policy options to address issues identified with the broader pandemic-related legislative framework.
Comment:	This aide-mémoire provides talking points to support you taking the paper to SOU.

Clare Possenniskie
Acting Group Manager
Public Health Policy and Regulation
Public Health Agency I Te Pou Hauora Tūmatanui

Talking points - Self repeal of the COVID-19 Public Health Response Act

s 9(2)(g)(i)

s 9(2)(g)(i)