Briefing

Draft Cabinet paper: February 2021 update on the COVID-19 Immunisation Strategy and Programme

Date due to MO:	15 January 2021	**Action required by:**	18 January 2021
Security level:	SENSITIVE	**Health Report number:**	20202320
To:	Hon Chris Hipkins, Minister of COVID-19 Response Hon Andrew Little, Minister of Health Hon Dr Ayesha Verrall, Associate Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Dr Ashley Bloomfield	Director-General of Health	S9(2)(a)
Caroline Flora	Acting Deputy Director-General, System Strategy and Policy	

Minister's office to complete:

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☐ See Minister's Notes	☐ Withdrawn	

Comment:

Draft Cabinet paper: February 2021 update on the COVID-19 Immunisation Strategy and Programme

Security level:	SENSITIVE	**Date:**	15 January 2021

To:	Hon Chris Hipkins, Minister of COVID-19 Response
	Hon Andrew Little, Minister of Health
	Hon Dr Ayesha Verrall, Associate Minister of Health

Purpose of report

1. This report provides you with a draft Cabinet paper *February 2021 update on the COVID-19 Immunisation Strategy and Programme,* for your review and Ministerial consultation, that responds to Cabinet's invitation for a report back on several issues related to the COVID-19 Immunisation Strategy and Programme. It also seeks your agreement to several of the policy issues included in the draft Cabinet paper.

Summary

2. This report attaches a draft Cabinet paper, to update Cabinet on 2 February 2021 on the COVID-19 Immunisation Strategy and Programme, for your review and Ministerial consultation. It includes proposals on a number of outstanding policy issues, including:
    a. updates to the Sequencing Framework based on the latest evidence, including more detail on who is included in the tiers and updating the groups considered most at risk of severe illness
    b. our progress on the Decision to Use Framework, which would help guide the best use of vaccines by providing a robust process to deciding to use a vaccine candidate
    c. the proposal to expand eligibility for COVID-19 immunisation to everyone in New Zealand, which would help us to maximise uptake of the vaccine. This would help reduce the risk of harm from COVID-19 and, over time, help us work towards population immunity.
3. Our advice on these issues is outlined in further detail in this report. We seek your decisions on these issues to ensure the draft Cabinet paper accurately reflects your position.
4. The draft Cabinet paper and proposals can be discussed at your Ministerial meeting on 18 January 2021 with the Prime Minister, the Minister of Research, Science and Innovation, the Minister of Foreign Affairs and the Associate Ministers of Health (Māori Health and Pacific Peoples). We have separately provided a briefing for Ministers to support this discussion (HR 20210037 refers).
5. Given the tight timeframes to meet the 2 February report-back, we seek any further feedback from Ministerial consultation by midday on 22 January 2021.

Recommendations

We recommend you:		Hon Chris Hipkins	Hon Andrew Little	Hon Dr Ayesha Verrall
Cabinet paper process				
1	**Note** the attached draft Cabinet paper to respond to the request for a report back by 2 February, which includes our recommended advice on a number of outstanding policy issues	**Yes/No**	**Yes/No**	**Yes/No**
2	**Agree** to provide the draft paper to relevant Ministers for Ministerial consultation, with feedback due by midday 22 January 2021	**Yes/No**	**Yes/No**	**Yes/No**
Decision to Use Framework				
3	**Note** that we have developed a draft Decision to Use Framework to help guide the best use of vaccine candidates, including what information should inform the decision to use (when and for whom), the decision window and the assessment process	**Yes/No**	**Yes/No**	**Yes/No**
4	**Endorse** the proposed Decision to Use Framework, noting that it will continue to be refined	**Yes/No**	**Yes/No**	**Yes/No**
5	**Note** that consultation with key stakeholders will begin following Cabinet's decisions	**Yes/No**	**Yes/No**	**Yes/No**
Sequencing Framework				
6	**Agree** to the proposed updates to the Sequencing Framework across the three transmission scenarios, noting changes are based on the latest available evidence and analysis of the risks from COVID-19	**Yes/No**	**Yes/No**	**Yes/No**
7	**Note** we are preparing for implementation on the basis of Scenario One: low/no transmission	**Yes/No**	**Yes/No**	**Yes/No**
8	**Note** that we will continue to review emerging evidence about the risk of serious illness faced by Māori and Pacific peoples, and will provide you with further advice on this in the coming weeks	**Yes/No**	**Yes/No**	**Yes/No**
9	**Agree** to seek Cabinet agreement to delegate decision-making to joint Health Ministers if changes are required under the Sequencing Framework	**Yes/No**	**Yes/No**	**Yes/No**

Eligibility to publicly funded COVID-19 immunisation

10	**Note** that enabling everyone in New Zealand, regardless of immigration status, to access to publicly funded COVID-19 immunisation: 10.1 would support our goal of working towards population immunity over time, and 10.2 can be absorbed within existing funding under current border settings	**Yes/No**	**Yes/No**	**Yes/No**
11	**Note** that to expand eligibility, the Minister of Health could establish a Ministerial Direction under section 32 of the Public Health and Disability Act 2000 (the Act), which requires consultation with DHBs			
12	**Agree in principle,** subject to consultation with Cabinet and DHBs, that eligibility to publicly funded COVID-19 immunisation either: 12.1 **Option one (not recommended):** aligns with the existing Eligibility Direction 2011	**Yes/No**	**Yes/No**	**Yes/No**
	OR	**OR**	**OR**	**OR**
	12.2 **Option two (recommended)** expands to include everyone in New Zealand regardless of immigration status	**Yes/No**	**Yes/No**	**Yes/No**
13	**Agree** that, as required under section 32 of the Act, we begin consultation with DHBs in January 2020 on a Direction to expand eligibility to publicly funded COVID-19 immunisation to everyone in New Zealand.	**Yes/No**	**Yes/No**	**Yes/No**

Dr Ashley Bloomfield
Director-General of Health
Date:

Hon Chris Hipkins
Minister for COVID-19 Response
Date:

Hon Andrew Little
Minister of Health
Date:

Hon Dr Ayesha Verrall
Associate Minister of Health
Date:

Draft Cabinet paper: February 2021 update on the COVID-19 Immunisation Strategy and Programme

The next update to Cabinet on the COVID-19 Immunisation Strategy and Programme is due early February 20201

6. On 7 December 2020, Cabinet considered advice on the COVID-19 Immunisation Strategy and Programme. It agreed that the purpose is to support best use of COVID-19 vaccines, which upholding and honouring Te Tiriti o Waitangi obligations and promoting equity [CAB-20-MIN-0509 refers].

7. The Prime Minister's office has requested that you report back to Cabinet on the COVID-19 Immunisation Strategy and Programme on 2 February 2021.

We have attached the requested draft Cabinet paper for your discussion and feedback, which includes advice on several outstanding policy issues

8. The attached draft Cabinet paper incudes advice to respond to the requested report-backs. It includes proposals related to the following outstanding policy issues:

    a. a Decision to Use Framework

    b. updates to the Sequencing Framework

    c. eligibility for COVID-19 immunisation.

9. In this briefing we outline in further detail our advice on these outstanding policy issues for your agreement.

10. The attached draft paper also includes updates on the following issues for Cabinet's information:

    a. progress with vaccine purchasing

    b. implementation preparedness (including GP vaccine administration fees)

    c. placeholder text which will be updated to reflect up to date progress of Medsafe's vaccine assessment

    d. placeholder text on arrangements for transferring vaccine portfolio management responsibilities from the Ministry of Business, Innovation and Employment to the Ministry of Health.

The Ministerial meeting on COVID-19 Immunisation is an opportunity to direct officials to make any revisions to the proposals

11. We understand that you are meeting on 18 January 2021 to discuss the draft Cabinet paper, updates on the COVID-19 Immunisation Programme, and the proposals in more detail with the following Ministers:

a. the Prime Minister

b. the Minister of Research, Science and Innovation

c. the Minister of Foreign Affairs

d. Associate Minister of Health (Māori Health)

e. Associate Minister of Health (Pacific Peoples).

12. We have provided you and the Ministers attending with a short briefing covering the draft Cabinet paper to support this discussion (HR 20210037 refers).

13. Given the short timeframes to make the 2 February 2021 Cabinet report-back, this meeting is an opportunity for you to discuss and come to an agreement on the proposals, and if required, direct officials to update the draft Cabinet paper.

A Decision to Use Framework will support the success of the COVID-19 Immunisation Programme by enabling best use of COVID-19 vaccines

The volumes of vaccines that we expect to purchase mean that we have more opportunity to choose how to use them

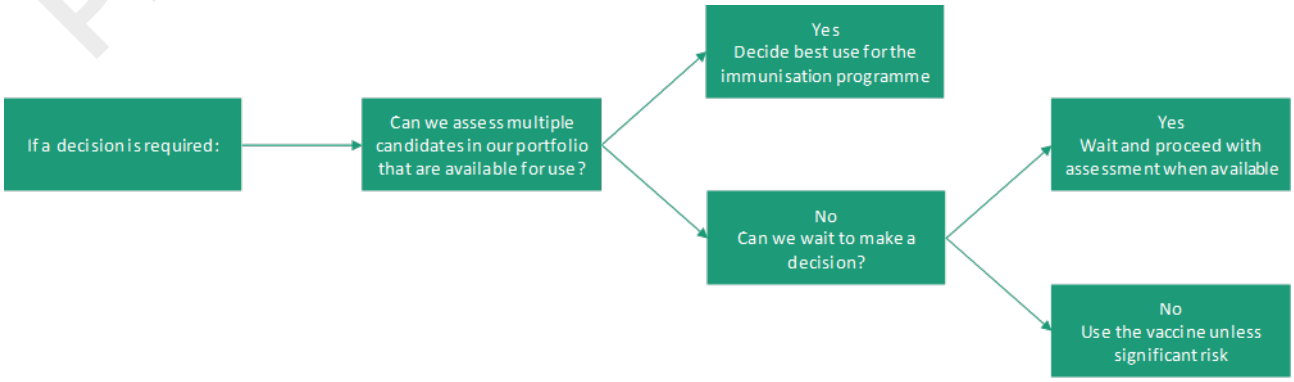
14. We are expecting to purchase up to 14.91 million courses of COVID-19 vaccines. The four vaccine candidates (Pfizer/BioNTech, Janssen, AstraZeneca's AZD1222 and Novavax's NVX-CoV2373) will vary in their suitability for different populations, safety, efficacy, price, number of doses, and in their storage, and distribution requirements.

15. These volumes mean that we will have the opportunity to choose which vaccines to use, when and how we use them to best support a successful COVID-19 Immunisation Programme. It is important to note that we will also provide advice on each vaccine candidate without knowing whether future vaccines will be more effective or suitable.

16. To inform decisions, we have developed a Decision to Use Framework to enable the best use of COVID-19 vaccines.

17. We may advise waiting, if possible, to enable us to make a better, more informed decision in the future. This is because we expect to have more certainty over time about the overall vaccine portfolio, as we get more information about each candidate and which will best support the objectives of the COVID-19 Immunisation Programme. Below we illustrate the "decision tree" at a high level:

Figure one: Decision tree for use of a vaccine candidate



18. The approach above assumes that we would likely recommend using the first vaccine candidate/s to be delivered, if we are unable to assess them against other candidates in our portfolio due to timing. This assumption is unlikely to change unless we have sufficient information that would mean:

    a. we can guarantee availability of another future vaccine that better supports the objectives of the Immunisation Strategy and Programme, or

    b. have negotiated further options through additional Advanced Purchasing Agreements (APAs) or the COVAX facility to further manage risk.

The Decision to Use Framework will help guide how the decisions are made

19. The table below outlines a number of following objectives guiding decision-making, based on the wider COVID-19 Immunisation Strategy principles:

	Immunisation Strategy principles	**What this means for the Decision to Use Framework**
Uphold Te Tiriti o Waitangi principles	Equity	Ensure the decision-making process upholds the principles of Te Tiriti o Waitangi, such as partnership and active protection as articulated by the Waitangi Tribunal in the Hauora report.
		Achieve equitable health outcomes, particularly for Māori
	Equal concern	Maximise uptake of the COVID-19 vaccine in line with the Sequencing Framework
	Minimise the health, social, economic and cultural harm of COVID-19	Best use of the vaccine portfolio to minimise the potential harm from COVID-19, based on the objectives in the Sequencing Framework
	Regional responsibility	Offering the Pacific any vaccines assessed as suitable for their use
	Value	Vaccine use is cost effective, minimising unnecessary wastage or duplicated effort
	Legitimacy	Decision-making is iterative and informed by the best evidence available

20. The Decision to Use Framework is centred around four key questions that need to be answered for each decision:

    a. **Context:** what is the context that the decision is being made in?

    b. **Decision window**: when do we need to make a decision?

    c. **Inputs**: what are the key pieces of information that inform our advice, including:

        i. **Clinical / Public Health** – vaccine(s) safety, quality, efficacy and effectiveness information.

        ii. **Population Coverage** – which population groups can be immunised with a particular vaccine, based on regulatory approval, volumes secured and suitability for particular population groups.

iii. **Equity** – whether the vaccine candidate would achieve equitable health outcomes by protecting those most at risk from COVID-19 infection (including Māori, Pacific peoples, disabled people, and older adults).

iv. **Customer experience / behaviour** – how likely is it that the particular vaccine candidate would support a positive consumer experience, and therefore higher uptake.

v. **Ease of implementation** – how ready we are to implement a particular vaccine, and how comparatively easy is it to deliver.

vi. **Fiscal** – the additional fiscal costs of how we use a particular vaccine.

d. **Assessment**: what are the benefits and risks?

21. Further detail on the context and decision window questions is outlined in **Appendix One**. The assessment alongside each of these questions has to provide a robust process that feeds into the advice and recommendations. It is proposed that the assessment of each vaccine candidate will:

a. identify the approach that would be taken to best support the COVID-19 Immunisation Programme

b. road-test the approaches, using the inputs and expected impact, validated through consultation with the experts that provides an in-depth view of the science and clinical information, immunisation programme, Te Tiriti o Waitangi, and priority populations

c. explore the outcomes and risks and identifying the best, worst and most likely impacts of each approach.

22. A key area of focus will be assessment of the vaccine candidate against the Te Tiriti o Waitangi principles. The table below outlines at a high level how the principles relate to the decision-making process:

Te Tiriti o Waitangi Assess, based on each input, whether the vaccine candidate will support us to uphold Te Tiriti o Waitangi	
Principle	**Relevant input(s) to consider**
Partnership	These will inform the Decision to Use assessment process
Tino Rangatiratanga	
Options	Ease of implementation (i.e. for Māori providers), population coverage, equity
Equity	Equity, population coverage (e.g. suitability for different age groups)
Active Protection	Clinical trial data, equity, customer experience

23. We anticipate that the final framework and process will need to be in place for an assessment for use of the Pfizer vaccine in February or early March 2021.

Due to time constraints wider engagement on the framework will have to commence post-Cabinet consideration

24. We need to consult more widely on the proposed Decision to Use Framework, which will enable us to refine the proposed approach and ensure that we have a robust process in place. However due to time constraints this will commence post-Cabinet consideration.

25. We intend to use the Stakeholder Network to consult with relevant stakeholders and partners such as Māori, District Health Boards, the health and disability sector, Pacific people representatives, and disabled people representatives.

We propose refinements to the Sequencing Framework based on the latest evidence

This advice has been superseeded by the most recent advice accepted by Cabinet

26. We have reviewed the latest evidence, including international data, on the risk of infection, transmission, severe illness and mortality for people living in New Zealand. This evidence highlights that risk of serious illness from COVID-19 increases more sharply with age than previously indicated by the evidence. Individuals with particular underlying conditions are also at increased risk of severe outcomes, as are pregnant women.

27. Based on this, we recommend refinements to Scenario One (low/no transmission), which are outlined in more detail at **Appendix Two**:

    a. Tier 1 (the border and COVID-19 frontline health workforce and their household contacts) is unchanged.

    b. Tier 2 (the second group to be prioritised) now:

        i. has a more limited focus on the higher risk health workforce, Police, and fire and emergency workers.

        ii. includes Aged Residential Care residents given their increased risk of transmission and serious illness.

        iii. has a smaller number of people, to ensure quicker transition to Tier 3, which is consistent with the evidence regarding risk.

    c. Tier 3 specifies in more detail protection of:

        i. vulnerable people who are most at risk of serious illness (particularly older people), and

        ii. those who provide health and social services that may or may not have a higher risk of infection, but they make a significant contribution to societal functioning and support cultural, social, and economic wellbeing.

Emerging evidence and operational considerations will inform the best approach to promote equity for Māori and Pacific peoples

28. The preliminary findings of recent statistical modelling indicate that Māori are 2.5 times, and Pacific peoples three times, more likely to be hospitalised with COVID-19.[1] Analysis in this modelling report (which is awaiting peer review and publication) indicates that a lower age threshold (compared to 65 years for the general population) for vaccinating Māori and Pacific peoples (21 years and 25 years lower respectively) could mitigate this additional risk of hospitalisation.

29. We are reviewing the emerging evidence of increased risk of infection, transmission, serious illness and mortality for Māori and Pacific peoples, alongside implementation

[1] Steyn, N. et al. *Māori and Pacific People in New Zealand have higher risk of hospitalisation for COVID-19*. Accessed 11 January 2021 at: https://www.medrxiv.org/content/10.1101/2020.12.25.20248427v1.full-text

options. This will inform future advice on the best approach to upholding Te Tiriti principles of active protection and equity, and promoting equitable health outcomes.

30. Because this group would be covered by Tier 3, and anticipated volumes mean that immunisation will likely not begin until the second delivery of vaccines, this issue does not need to be resolved for the February 2021 Cabinet paper.

We also suggest refinements to the other Sequencing Framework scenarios (where New Zealand is facing controlled outbreaks or widespread transmission)

31. The Ministry of Health is currently preparing to implement the COVID-19 Immunisation Programme under Scenario One (low/no transmission). However, if transmission increases, this could necessitate a shift to one of the other sequencing scenarios.

32. We propose to refine Scenario Two (controlled outbreaks) to mostly replicate changes to Scenario One sequencing, noting it also has an additional provision to prioritise vaccinating groups affected by the outbreak at the local level. This would only occur if the characteristics of the vaccine indicate that immunisation is an appropriate part of wider public health outbreak control measures. It would include protecting vulnerable groups and close contacts of outbreak cases as defined by testing and tracing guidance.

33. We propose refinements to sequencing under Scenario Three (widespread community transmission) to align with the other changes so that it would immediately protect our most vulnerable populations from COVID-19 as identified in the latest evidence on the risk to older people and people with specific conditions. It will then progressively move towards protecting the health and public sector workforces, starting with those who are at greatest risk of infection and transmission.

The Director-General will clarify any minor operational implications of the Sequencing Framework as needed

34. We will continue to assess the potential occupational exposure to COVID-19 of other workforces to determine whether other groups should be included in the proposed sequencing. Note that the Director-General of Health may make minor inclusions within the proposed tiers under the preferred scenario on a case-by-case basis to provide ease of implementation.

35. If substantial changes are required to the Framework, or the transmission situation necessitates a change in the sequencing scenario, we recommend seeking Cabinet agreement to delegate decision-making to joint Health Ministers.

36. Recent discussion with the five eyes countries have highlighted that while prioritisation or sequencing is a useful tool to help manage a limited vaccination supply, it needs to be applied pragmatically to ensure the programme runs smoothly and the distribution of vaccines to remote communities happens efficiently.

Expanding eligibility for COVID-19 immunisation to everyone in New Zealand will help us maximise uptake

37. Immunisation is publicly funded for eligible people specified in the Health and Disability Services Eligibility Direction 2011. In general, this would include all:

    a. children

b. New Zealand citizens (including people from Cook Islands, Niue and Tokelau) and permanent residents

c. refugees and protected persons

d. Australian citizens or permanent residents who have lived, or intend to live, in NZ for two years or more

e. people with a valid work visa who will be in NZ for at least two years.

38. This means adults on temporary visas or who are Australian citizens that will be in NZ for less than two years, or people who are in NZ unlawfully, would not be eligible for a publicly funded COVID-19 vaccine at present.[2] Our estimates suggest this could include approximately up to 280,000 people.

39. As was seen with the 2019 Measles Outbreak, community transmission of infectious diseases can occur among groups who are not normally eligible for immunisation, potentially putting the individuals, their whānau and their community at risk. Maximising uptake of the COVID-19 vaccine will be essential if we are to reduce the risk of harm from COVID-19 and, over time, achieve population immunity. It also enables us to contribute to the global effort working to end the pandemic.

40. Given this, we propose that everyone in New Zealand should be able to access free COVID-19 immunisation. This includes people in New Zealand temporarily (for example, Recognised Seasonal Employer (RSE) workers) and people in New Zealand unlawfully. **Appendix Three** includes an options analysis of this proposal against the COVID-19 Immunisation Strategy principles.

41. This option is consistent with the draft advice from the National Ethics Advisory Committee:

From an epidemiological perspective, all individuals living in a geographic area (such as New Zealand) must be considered as part of the immunisation programme, regardless of their immigration status. This includes all non-residents currently living in, or unable to leave, New Zealand.[3]

42. It is also consistent with access to COVID-19-related healthcare, which is available to everyone in New Zealand.

43. We did consider an option to limit the expansion in eligibility to only people "living in New Zealand", i.e. including people on work visas and student visas (and potentially Australians), but excluding people on visitor visas. We discounted this option for a number of reasons:

a. It does not align with the COVID-19 Immunisation Strategy principles, in particular equity, regional responsibility and equal concern.

[2] **While there is a clause that enables the diagnosis or treatment of anyone suspected of having a quarantinable disease immunisation is preventative and will generally not be given to a person "who has, or is suspected of having, and infectious disease".**

[3] **National Ethics Advisory Committee, Ethics and Equity: Resource Allocation and COVID-19: An Ethics Framework to Support Decision Makers (draft version, 2020).**

b. There would need to be a clear threshold for "living in New Zealand", i.e. how long would the individual have to intend to be in New Zealand for, which would be make implementation more complex.

c. It would be difficult to enforce without requiring some proof of immigration status, which would create a barrier to uptake.

d. There are still people on visitor visas in New Zealand that are unable to return to their home country at present, who we should encourage to be immunised.

e. This option would make it difficult to justify including, as eligible, those who are in New Zealand unlawfully. This would be problematic given this group could be especially vulnerable to the risks of COVID-19 and reluctant to engage with the Government.

A new Ministerial Direction could expand eligibility for COVID-19 immunisation to non-residents

44. Should Cabinet agree in principle to the policy proposal, we recommend that the Minister of Health pursue a standalone direction on COVID-19 Immunisation Eligibility under section 32 of the New Zealand Public Health and Disability Act 2000. A standalone direction, rather than an amendment to the existing Health and Disability Services Eligibility Direction, provides more flexibility with drafting and duration. As well, it makes it clear that the policy change is limited to the COVID-19 immunisation only.

45. This process requires consultation with DHBs, which we anticipate would take at least two weeks. Subject to your agreement, this can run in tandem to the Cabinet paper process. We will provide further advice in February 2021 on the DHBs feedback for the Minister of Health's consideration, accompanied by the drafted Ministerial Direction.

46. Note that the final decision on the Direction sits with the Minister and not Cabinet, and there needs to genuine consideration of the consultation feedback. While we do not anticipate the need recommend a change to the policy position, the Minister could update Cabinet if any changes are made.

Under current border settings, the fiscal cost can be absorbed within existing funding

47. We expect that the cost of expanding access can be absorbed within the existing appropriation while visitor numbers are low. We do not have a robust estimate of the number of people who would take up COVID-19 immunisation that would not have otherwise if they remained ineligible. However, as an indication, it would cost approximately $17 million to immunise up to 280,000 people.

48. We expect that at present the cost could be absorbed because:

a. our previous fiscal estimates assumed 100 percent uptake of the vaccine, which is unlikely to occur (either for citizens/residents or non-residents)

b. the allocated funding includes a contingency for any unexpected costs.

49. Any future policy work to relax border controls would need to consider the impact on COVID-19 immunisation eligibility, given that relaxing the borders would increase the number of people on temporary visas.

50. If borders were to open, additional funding may be required if the proposed policy was to continue, given we could expect a significant increase in visitors who may not be

vaccinated.[4] However, it may not be cost effective for the Government to fund COVID-19 immunisation for large numbers of people on visitor visas who will only be staying in New Zealand for a short time. This is because immunising this group is unlikely to contribute to population immunity.

51. Given this, alternative options or change to the policy may need to be considered when looking at changes to border settings.

Other updates in the draft Cabinet paper

52. The draft Cabinet paper also provides information on progress with vaccine purchasing and the implementation of the COVID-19 Immunisation Programme, such as communications and funding models.

53. These sections of the paper will continue to be updated throughout the drafting process to ensure the information is current.

Equity

54. As previously advised, delivering on the COVID-19 Immunisation Strategy may contribute to the full cultural, social and economic recovery from COVID-19, and has potential flow-on implications for specific population groups at increased risk of adverse social, cultural and economic outcomes. In respect of the proposals in this paper, there are a number of key equity implications:

    a. The Decision to Use Framework has potential to support or undermine equity, which is why equity is identified as a key input to the decision-making.

    b. We will continue to review the best approach to promote equitable outcomes for Maori and Pacific peoples, including consideration of a lower age threshold Māori and Pacific older people.

    c. Making free COVID-19 immunisation available to everyone in New Zealand promotes equity for anyone regardless of immigration status.

Next steps

55. Officials are working to the condensed timeframe for the Cabinet paper, as set out below. This timeframe aims to maximise time for Ministerial consideration of the draft Cabinet paper.

Timeframe	Milestone
Monday 18 January	Draft Cabinet paper is sent out for Ministerial consultation
Monday 18 – 22 January	Ministerial consultation underway, including Ministers meeting to discuss the proposals on 18 January

[4] **The draft Cabinet paper includes a breakdown of the estimated number of people this policy changes could impact. As at November 2020 there were only approximately 32,000 people on visitor visas in New Zealand.**

Wednesday 20 January	Feedback from agency consultation due
Midday on Friday 22 January	Ministerial feedback on Cabinet paper due
Wednesday 27 January	Final Cabinet paper for your approval
Thursday 28 January	The Cabinet paper is lodged by the Minister of Health's office
Monday 2 February	Cabinet meeting

56. In addition to those who will attend the Ministerial meeting on 18 January 2021, we suggest the updated Cabinet paper is provided to other relevant Ministers for their and comment, such as the Minister of Immigration.

57. Given the tight timeframes, we are seeking feedback from Ministerial consultation by midday on Friday 22 January. We will then incorporate any changes before providing you the final Cabinet paper for lodgement on 27 January 2020.

Appendix One: Supporting information for the Decision to Use Framework

59. Below we outline in more detail some of the information that forms part of the Decision to Use Framework. This content is included within the draft Cabinet paper (attached).

In what context is the decision being made?

60. Like the COVID-19 Immunisation Strategy and Programme, context will be key to any decision, for example, we will need to consider:

    a. the ongoing risk of COVID-19, levels of community transmission and disease incidence in New Zealand

    b. changes to system settings or public health measures, for example the alert levels or border settings

    c. progress of the COVID-19 Immunisation programme, including the number of COVID-19 vaccines available in the country and the delivery schedule and population groups across the portfolio

    d. population coverage for particular groups e.g., if the first vaccine isn't suitable for a population (e.g. young people) then vaccinating this group with future vaccines will be a key consideration.

    e. a shift in our objectives, for example uptake to achieve population immunity or whether the vaccines only reduce incidence of serious illness but do not prevent transmission.

When do we need to make a decision?

61. We anticipate that there will be a sequence of decisions or decision windows for each vaccine as it is approved for use in New Zealand. These decision windows show where it is feasible to consider multiple vaccines in our portfolio for use.

62. The decision window is likely to follow from regulatory approval and needs to be made for each vaccine before it becomes unfeasible to deliver the vaccine. The A3 on the next page outlines when we are likely to have to make these decisions, based on information as at 21 December 2021.

s 9(2)(g)(i), 9(2)(j)

[redacted]

Appendix Two: Low/no community transmission sequencing scenario

Tiers and groups			Comment
Tier 1	**1a. Border and MIQ workforce** **1b. COVID-19 frontline health workers** **(potentially exposed to COVID-19 cases/samples)** • public health units, testing (swabbing and laboratory analysis), providing hospital transport, diagnosis and treatment for COVID-19 patients (ambulance, ED, ICU, wards), vaccinators **1c. Household contacts**[5]		No significant changes. Note that 1a refers to the workforce subject to the compulsory testing under the COVID-19 Public Health Response (Required Testing) Order 2020. 1b includes additional examples of health workers. 1c aligns with the Census definition and data, for the purpose of population allocation, we are estimating three household contacts per worker (this is detailed in the glossary).
Earlier version provided to Cabinet in December 2020		**Refinement**	**Comment**
Tier 2	Protect rest of health workforce, and high-risk essential public/industry workers	**2a. Frontline high-risk health workforce** • Aged Residential Care (ARC) • Other aged care and in-home disability support • Maternity • Diagnostics – radiology, laboratories • Treatment services for most vulnerable people – e.g. radiotherapy, dialysis • Primary care (roll-out to start with localities closest to the borders) - general practice and iwi-based services, Well Child/Tamariki Ora **2b. Aged Residential Care residents** **2c. High risk frontline public sector** • Police • Fire and emergency	This tier focuses on critical occupations in the health and emergency systems and reflects a key focus on protecting the health system's ability to continue to function as normally as possible. It includes groups that: • work with a high number of clients, in close proximity for sustained periods, more often with the most vulnerable client groups, and are unable to maintain physical distancing; and • have less risk of infection than COVID-19 frontline, but higher risk than the general population. The tighter definition of frontline health workers is based on risk of exposure to COVID-19 cases and vulnerable people. The smaller number in this group means that vaccine roll-out to the most vulnerable people in the community can occur sooner. Tier 2 now also includes ARC residents. COVID-19 has spread rapidly through ARC facilities in New Zealand and internationally, and the residents are at significantly higher risk of serious illness and death if they contract COVID-19. The ARC workforce and residents can likely be vaccinated at the same time.
Tier 3	Protect vulnerable populations, promote wider recovery, starting with immune compromised (older people).	**3a. People at greatest risk of serious illness** • All people aged over 65 years, starting with 75+, then 65+ • All people aged under 65 years with relevant underlying conditions, including disability, coronary heart disease, hypertension, stroke, COPD/respiratory illness, diabetes, kidney disease • Pregnant women and household contacts **3b. Health and Social Services** • People working in long-term residential care settings • Other primary and community-based health care, e.g. pharmacy, physiotherapy, occupational health, oral health • Social, community and youth workers, Kaiāwhina • Whānau Ora • Early childhood care, primary, secondary, tertiary teachers • Mental health and addiction service workers • Screening services	This tier focuses on: • people with the most significant risk factors for serious illness and death – increasing age, relevant underlying conditions, pregnancy; and then • occupations that may or may not have a higher risk of infection, but they make a significant contribution to societal functioning and support cultural, social, and economic wellbeing. Evidence (including risk modelling) is emerging for key high-risk groups, including Māori and Pacific peoples, and pregnant women. This evidence will be reviewed alongside operational considerations to determine the best approach. **For Tier 3 onwards**, sequencing could be based on Community Services Card or region/locality as a proxy to reach those at greatest risk (e.g. New Zealand Deprivation Index). This would address equity and support implementation.

[5] Adjusted to exclude children and young people who are unsuitable for the vaccine.

Appendix Three: Options analysis of eligibility settings for publicly funded COVID-19 Immunisation

COVID-19 Immunisation Strategy principles	**Option one (status quo) –** some groups are not eligible for COVID-19 immunisation based on residency status	**Option two –** everyone in New Zealand is eligible for free COVID-19 immunisation
Equity	-1 *This option would not lead to equitable treatment for non-residents, however it is consistent with their eligibility to other types of immunisation.*	2 *This option would treat everyone in New Zealand equitably, regardless of their immigration status.*
Equal concern	-2 *This option would not treat non-residents as of equal concern.*	2 *This option would treat non-residents as of equal concern.*
Minimise the health, social, economic and cultural harm of COVID-19	-1 *This option would not directly protect non-residents from the harm of COVID-19. Given undocumented communities may be more reluctant to engage with officials, this is a concern.* *However, they may still receive some "flow-on" benefits from others being immunised in their community.*	2 *This option could protect non-residents who are immunised, which over time could contribute to achieving population immunity and minimising the wider economic impact of COVID-19. It would also reduce the risk of social and cultural harm to non-residents.*
Regional responsibility	-1 *This option may create a discrepancy, where non-residents can get immunised for free in their home country (funded by NZ), but not if they are living in New Zealand.*	1 *Some non-residents will be citizens of the participant Pacific countries, for example the majority of RSE workers are from the Pacific.*
Value	1 *This option would lower the cost of the COVID-19 Immunisation Programme.* *However, non-residents are already eligible for treatment if they have COVID-19 which could be considerably more expensive (on an individual basis) than immunisation.*	-1 *This option would increase the cost of the COVID-19 Immunisation Programme, as potentially up to 280,000 additional people could be eligible.* *This group may also only be in New Zealand for a short period of time after immunisation, so New Zealand may receive less benefit.*
Legitimacy	-1 *This option is not evidence-based. It may erode trust if people become concerned that non-residents are likely to transmit COVID-19.*	1 *This option is evidence-based and may help build confidence that the COVID-19 Immunisation Programme is doing everything to achieve population immunity.*
Average rating	**-0.8**	**1.2**

ENDS.