In Confidence

Office of the Minister for COVID-19 Response

Office of the Minister of Health

Cabinet Social Wellbeing Committee

Integrating our immunisation approach and providing population protection against vaccine preventable diseases in 2022

Proposal

1 This paper seeks your consideration to:

1.1 endorse the direction of the strategic approach integrating immunisation programmes to ensure population protection against the full range of vaccine preventable diseases,

1.2 agree to draw down on the 'Minimising the health impacts of the COVID-19 Tagged Operating Contingency' to fund the remainder of phase 1 of the COVID-19 vaccinations programme and appropriating additional funding to continue COVID-19 vaccinations in 2022 including the booster programme, and

1.3 agree to fund the expanded influenza programme for 2022 subject to further advice to Vaccine Ministers.

Relationship to government priorities

2 The proposal in this paper supports New Zealand's ongoing response to the COVID-19 pandemic and achieving its goals through a wellbeing approach.

3 The proposal is in line with Government commitments under the Child and Youth Wellbeing Strategy particularly when working to ensure the best health outcomes for children and young people.

Executive Summary

4 The COVID-19 pandemic has exacerbated existing pressures on the New Zealand health and disability system, with increasing equity gaps and declining childhood immunisation rates. Our COVID-19 context is changing as we shift to a vaccination-led response through the COVID-19 Protection Framework. Reconnecting New Zealanders with the world is the next step in regaining many of the freedoms, and social and economic connections of our pre-COVID-19 lives.

5 The COVID-19 response has created infrastructure and learnings on immunisations which need to transition into an integrated immunisation approach. It has been a collective effort involving many groups across New Zealand, including hapū, iwi, hapori Māori (Māori communities) and Pacific communities.

6 This strategic approach will enable better delivery of all immunisation programmes alongside the COVID-19 vaccine programme in 2022. It will set the direction and vision for immunisations in the context of our Te Tiriti obligations, Whakamaua and Ola Manuia, ensuring equity for Māori, Pacific people and disabled people.

7 Maximising uptake through broad and targeted communication, engagement, a strengthened vaccinator workforce and equitable service delivery models, informed by learnings and insights from the COVID-19 vaccination programme and other immunisation programmes will support this strategic approach. By taking this approach we will aim to improve childhood immunisation rates, particularly the Measles Mumps and Rubella (MMR) catch up campaign and prioritise the seasonal influenza vaccinations in 2022. The prevalence of influenza will likely be greater in 2022 when borders open, placing additional pressure on the public health system.

8 Officials are taking incremental steps before the end of the year to transition from a COVID-19 response to a more strategic response and focussing on immunisations more broadly. Planning has already started for immunisation programmes in 2022, including the continued roll out of the COVID-19 vaccination programme, but more importantly ensuring that we are well prepared to meet any potential high demand for other immunisations, particularly influenza in 2022. Decisions are needed now on funding and eligibility changes to be communicated to the sector and New Zealanders to ensure a smooth transition to a strategic approach.

Background

9 In 2021, New Zealand embarked on the most significant immunisation campaign in the country's history, aiming to vaccinate everyone in New Zealand aged of 12 plus against COVID-19. The achievements and progress made under the COVID-19 vaccination programme are the result of many factors including increased workforce, supply, logistics, communications, scientific evidence, agility, managed incentives, collaboration and kotahitanga. At the same time, the COVID-19 pandemic has had a significant impact on the wider area of vaccine preventable disease in New Zealand.

10 As the country moves to reduce border restrictions as part of reconnecting globally, the associated population movement raises the risk of re-introduction of seasonal influenza as well as importation of highly infectious vaccine preventable diseases such as measles and pertussis (whooping cough). New Zealanders will be particularly vulnerable due to a potential reduction in immunity against vaccine preventable diseases.

11 Our strategic approach to immunisation for the full range of vaccine preventable diseases under the COVID-19 Protection Framework will work in tandem with the approach to reconnecting to the world to minimise COVID-19, protect public health and avoid overwhelming the health system, while driving social and economic recovery.

12 Public health measures and COVID-19 restrictions have led to a decline in cases of vaccine preventable diseases. The public health pressures remain high and those vulnerable in the community are most likely to be impacted.

13 Ensuring the resilience of the public health system remains important and in line with the ongoing Health and Disability Systems Reform. The Ministry of Health (the

Ministry) remains committed to ensuring the current health and disability system continues to deliver through the transition for all New Zealanders. Knowledge and resources developed through the COVID-19 vaccination programme can be used to strengthen wider immunisation efforts and integrate them into a national immunisation programme.

Analysis

Immunisation programmes have been impacted by the COVID-19 pandemic

14 Providing the COVID-19 response has stretched and challenged the health system. It has led to an inevitable prioritisation of resources and emphasis away from other immunisation programmes, despite actions put in place to increase overall system capacity including increasing the vaccinator workforce. At the same time, the COVID-19 response has provided insights and learnings which can be leveraged into other immunisation programmes.

15 Uptake of immunisations in priority groups has dropped in recent years and has been further exacerbated by the pandemic with childhood immunisation rates declining even before COVID-19. Childhood immunisation rates declined further over 2020 and 2021 as the COVID-19 response took precedence (see Appendix 1 for recent quarterly childhood immunisation rates). The World Health Organization (WHO) has identified this is as a global issue with childhood immunisation rates also decreasing globally. Improving childhood immunisation rates remains a priority now and in 2022 as we transition towards an integrated immunisation approach.

16 Some of immunisation programmes impacted by the COVID-19 pandemic include the Measles campaign and the Human Papillomavirus (HPV) immunisation programme. Measles cases continue to be reported worldwide and there is a high risk that the virus will be imported into New Zealand when borders reopen. This importation may have a higher impact than in 2019 during the measles outbreak with the campaign to address the known immunisation gap in 17- to 32-year-olds being paused due to the COVID-19 pandemic, alongside declining childhood immunisation rates. Likewise, the HPV programme, delivered through the school programmes, was impacted by lockdowns and with the school programme workforce (public health nurses) being redeployed to COVID-19 swabbing and vaccinations.

17 With the exception to the influenza vaccination, which increased in 2020 by 33 percent from the previous year to reach a record level, access to most immunisations during lockdowns (and periods thereafter) decreased despite the continued messaging to continue with immunisations. Inequities continued to increase during this time – particularly for Māori, Pacific people and disabled people.

Taking a strategic approach will set the future pathway to improve immunisations through an integrated approach

18 A strategic view of immunisation in New Zealand for 2022, incorporating the COVID-19 vaccination programme into a national immunisation programme, provides an opportunity to adopt an integrated approach to all immunisation programmes. Evidence and insights from the COVID-19 vaccination programme and other immunisation programmes have identified initial areas to focus and engage on for 2022. A general overview of the scope and areas of focus is set out in Appendix 2.

19 Immunisation programmes continue to have broader systemic issues that existed prior to the COVID-19 pandemic. Alongside the Health and Disability Systems Reform currently ongoing, improving current models to better support whānau, address wider wellbeing needs and immunisation needs particularly for children are some of the ways to address these broader systemic issues.

20 Although equity of access and vaccine hesitancy remain the main challenges, our strategic approach will continue to be guided by the principles of equity, active protection, options, partnership, and tino rangatiratanga. These principles speak to the need to support a holistic approach that will contribute to a stronger, more aligned and resilient health and disability system, while recognising the differential health outcomes and ensuring equity for Māori, Pacific people and disabled people. The approach will continue to support co-ownership, improved coverage, fair and equitable access, trust and confidence while continuing to apply kaupapa Māori principles and remain Pacific focused. Technology development, expanded workforce capacity, novel service delivery models, and increased partnership with Māori and Pacific providers are some of the elements that allow for opportunities for a different way of delivering immunisations and remain in line with the ongoing health sector reforms.

21 Our strategic approach will focus on integrating the current immunisation programmes and learnings and insights from the COVID-19 vaccination programme in 2022. This includes a preparedness to meet any potential high demand for immunisations as we look to maximise uptake in 2022.

Our immunisation priorities will allow us to shift our focus towards an integrated immunisation approach

22 Our immunisation priorities are already looking towards integrating into a broader national immunisation programme. As we transition to the COVID-19 Protection Framework a wider strategic response to immunisations, population protection remains the key objective for New Zealand.

23 The system immunisation priorities over the next nine months to June 2022 can be considered in three-month blocks:

23.1 **October to December 2021** – fully vaccinating over 90 percent of New Zealand's eligible population with the COVID-19 vaccine, commencing the COVID-19 booster programme (booster programme), and rapidly relaunching the national measles immunisation campaign for children and young people under the age of 32 who have not had two MMR vaccinations.

23.2 **January to March 2022** – vaccinating children aged between 5 and 11 years with the COVID-19 vaccine (pending regulatory approval); improving childhood immunisation rates with a considerable focus on addressing inequitable coverage for tamariki Māori and Pacific children; and continuing the booster programme.

23.3 **April to June 2022 –** continue with the booster programme and influenza vaccination effort before winter 2022, to protect the population and reduce pressure on the health system.

24 As part of the shift in focus, the existing National Immunisation Register is being replaced with the National Immunisation Solution (NIS) and builds from the COVID-19 Immunisation Register. Key business functions and capabilities as part of the COVID-19 Immunisation Register will be leveraged to support the ongoing development of the NIS. The NIS should be operational in 2022 allowing for accurate recordings of all vaccinations, particularly adult vaccinations that are currently under-recorded.

25 Innovations and experiences from the COVID-19 vaccination programme that could be applied in an integrated immunisation approach includes, consideration of expanding the publicly funded eligibility criteria for the influenza vaccine, outreach service delivery, communication and education, devolving funding and building the workforce. These could be through early planning, expanding the COVID-19 vaccinator workforce, and ongoing implementation of the Māori Influenza and Measles Vaccination Programme (MIMVP).

26 Our focus on immunisations for 2022 will be to maximise uptake through leveraging off the knowledge, infrastructure and delivery models developed through the COVID-19 vaccination programme which could potentially assist in bringing in efficiencies for broader immunisation programmes. These will build upon key relationships built within the health system, across the public sector and with community organisations that can be harnessed for future immunisation programmes and eventually be integrated under the reformed health system.

As we work towards an integrated approach, delivery of COVID-19 vaccinations will still need to continue into 2022

27 The goal of the COVID-19 vaccination programme is to provide all those eligible in New Zealand with opportunity to be fully vaccinated, whilst upholding the Crown's obligations under Te Tiriti o Waitangi. As of 6 December 2021, 94 percent of the eligible population aged 12 and over have received their first dose of the COVID-19 vaccine and 88 percent are fully vaccinated. 85 percent of Māori have received their first dose and 92 percent of Pacific people have received their first dose.

28 There is more work still to be done, including delivery of the booster programme and extending the COVID-19 vaccination programme to children aged from 5 to 11 years old, subject to regulatory and Cabinet approval. Significant resources are still expected to be required to operationalise any further decisions made on the COVID-19 vaccination programme including to:

28.1 fund the administration of vaccine doses, and

28.2 continue the development and delivery of digital tools, for example required the COVID-19 vaccine pass.

29 While we have significant data on the costs of delivering the COVID-19 vaccination programme to date, data is still being collected and reported to the Ministry. We are still learning about the range of costs involved in end-to-end national delivery.

30 During the roll-out in 2021, District Health Boards (DHBs) and providers have improved the effectiveness and efficiency of their delivery sites and have refined set up and operations, but costs have varied significantly by site type (estimated to be

from less than s 9(2)(b)(ii) cost per dose delivered), and by DHB, depending on the differing needs of the populations in each region.

31 Planning for continued delivery of the COVID-19 vaccine into 2022 incorporates intelligence that has been gained through the 2021 roll-out and an assumption of the number of people that will need to receive a dose of the COVID-19 vaccine. It's expected that approximately 5.4 million doses will still need to be administered in 2022. This includes COVID-19 boosters and vaccines for children aged from 5 to 11 years old.

32 Based on evidence to date, the Ministry estimates costs to administer boosters and vaccines for children in 2022 may range from s 9(2)(b)(ii), as outlined in Appendix 4, dependent on the additional supports required for populations who experience more challenges in accessing services. s 9(2)(b)(ii) Further funding may be required as the programme continues.

33 s 9(2)(f)(iv) There may be an opportunity in the new year to consider what further resources the Ministry requires overall to respond to COVID-19 in 2022 as part of advice that will be brought to Cabinet on Health System Preparedness.

34 It has therefore been estimated that s 9(2)(f)(iv) is needed to maintain operational readiness for the COVID-19 vaccination programme into 2022 and deliver the large scale of vaccinations required.

35 There is funding still available in the tagged contingency for the COVID-19 vaccine programme in 2021, and given a forecast underspend for 2021, Cabinet is asked to draw down s 9(2)(f)(iv) from the established tagged contingency and appropriate a further s 9(2)(f)(iv) to complete phase 1 of the COVID-19 vaccine programme in 2021 and commence the continuation of the COVID-19 vaccine programme into 2022.

36 While the Ministry has led the purchase of COVID-19 vaccines since 2020 (initially working with MBIE), the supply of COVID-19 vaccines by pharmaceutical companies is now plentiful. s 9(2)(f)(iv)

37 Delivering other immunisations alongside the COVID-19 vaccination programme is an example of how the Ministry is considering its integrated approach to improve uptake of immunisations. The COVID-19 Vaccine Technical Advisory Group (CV TAG) has advised that the influenza vaccine (and other vaccines) can be administered concomitantly with the Pfizer COVID-19 vaccine for those over the age

of 12 years, without concern for spacing of the vaccines, which will greatly improve the ease of vaccine delivery. However, on co-administering the Pfizer COVID-19 vaccines with other immunisations for children aged 5 to 11 years old, CV TAG has yet to provide any advice and this will likely only happen in 2022 once further evidence from the Northern Hemisphere winter comes out.

Seasonal influenza vaccination needs to be prioritised in 2022 to protect our communities as we reconnect New Zealand

38 It is likely that the 2022 seasonal influenza season will have a greater health impact than of the previous two years. Whilst sporadic cases of influenza virus infection have been detected in New Zealand's managed isolation and quarantine (MIQ) facilities in 2020/21, the strict border controls for international travellers have led to no circulating influenza virus detected in New Zealand since early in 2020.

39 The New Zealand population will be particularly vulnerable as immunity to this virus will have waned due to lower exposure for two. As a result, priority needs to be given to ensuring maximum uptake of seasonal influenza vaccination in 2022.

40 Increasing influenza vaccination rates and maximising uptake in 2022 will be important to also ease unnecessary pressures on the public health system through decreasing the winter burden on health services.

41 In line with our objective to strengthen population protection, expanding the eligible groups for a publicly funded influenza vaccination in 2022 will be part of our COVID-19 response. It will provide an opportunity to incorporate the successful learnings and insights from the COVID-19 vaccination programme through an integrated immunisation approach.

42 Minimising the burden of influenza illness, hospitalisation and death remains an equity issue. While our most vulnerable community members (particularly young children, older people, pregnant people and people with underlying medical conditions) are already eligible for a funded vaccination, the equity gap still remains high within these groups.

Expanding the publicly funded influenza immunisation programme in 2022 is a key part of our immunisation priorities

43 The Ministry provided advice to Vaccine Ministers in September 2021 on potentially expanding the eligibility group for publicly funded influenza vaccinations in 2022. This was also in line with CV TAG advice that a public/private joint model is incompatible with public health principles and that universal access to funded influenza vaccines would be more effective at protecting the entire population.

44 Under the current funding model, there is one pool of influenza vaccines that is shared between the publicly funded market for eligible people and the privately funded market. The total pool of influenza vaccines each year is composed of the volume of vaccine committed by Pharmac's preferred supplier (Seqirus) for both markets. Pharmac and Seqirus have agreed on the supply of 1.7 million doses of influenza, which is intended to supply both the public and private market in 2022.

45 Pharmac's role is set out in the Memorandum of Understanding (MOU) with the Ministry, Pharmac and District Health Boards (DHB). Except for the COVID-19

vaccination programme, Pharmac's role includes determining the eligibility criteria for all publicly funded (free) vaccinations. The MOU also provides that the Ministry can work closely with Pharmac to explore opportunities to maximising immunisation goals. Changes to the policy settings for eligibility would require a review of the MOU.

46 Those currently eligible for a publicly funded influenza vaccination include:

46.1 people aged 65 years and over

46.2 pregnant people

46.3 those with certain chronic or serious conditions (such as heart disease, cancer, or serious asthma)

46.4 young children aged under 5 with a history of serious respiratory illness.

47 Although the current eligible group for publicly funded influenza vaccinations is broad enough to cover those considered to be generally at a higher risk due to the COVID-19 pandemic, we are of the view that to ensure the best protection for our population, expanding the current eligibility groups for publicly funded influenza vaccinations in 2022 (subject to securing additional supply of vaccines) will be an important step to achieving our broader health objectives.

48 We propose that the Ministry work with Pharmac to provide further advice to Vaccine Ministers on expanding the influenza immunisation programme early next year, including identifying which groups eligibility for publicly funded vaccinations should be expanded to. As part of this further advice, we seek your agreement that the Ministry, together with Pharmac, give initial consideration to the following groups:

48.1 Māori and Pacific people aged from 55 to 64 years old

48.2 Children aged 6 months to 17 years old.

49 Utilising an age-based prioritisation for influenza immunisations, alongside other strategies is a necessary additional step to improve on equitable immunisation rates. Māori and Pacific people bear a disproportionate burden of disease along-side over representation in poorer quality and overcrowded housing. Māori are also less likely to live to the age of 65 where they would be eligible for funded influenza immunisation. Based on current COVID-19 vaccination rates and slower uptake in Māori, current strategies employed (i.e. whanau-centred delivery, outreach services) were not sufficient in mitigating inequitable vaccination uptake rates. By utilising an age-based prioritisation for influenza, not only do we focus on reducing the health risks but also ease the pressures on the public health systems.

50 Māori and Pacific people aged from 55 to 64 years old were considered by Pharmac's Immunisation Subcommittee, which had observed that higher mortality from influenza in Māori and Pacific populations is related to lower coverage in these groups. It had also considered that current coverage of targeted groups was not high, so expanding eligibility to Māori and Pacific people from a younger age did not address the low coverage. While the Immunisation Subcommittee recommended to decline this proposal, as it considered that increasing coverage was the best means to protect more Māori and Pacific people, a final decision has yet to been made by Pharmac.

51 Children aged from 6 months to 17 years old have been included as one of the targeted groups for consideration for a publicly funded influenza vaccine, as children are usually the ones who spread the virus more easily into the community, particularly to older people in intergenerational households. Further advice will give consideration as to whether this age band should be further narrowed. Consideration will be given to children aged from 5 to 11 years old (to leverage the possible COVID-19 co-administration), or from 6 months to 5 years old (following WHO standards as well as countries like Australia), 6 months to 17 years old (the UK has taken this approach).

52 The rationale and approximate high level cost implications for expanding to the proposed targeted demographic groups are further elaborated in Table 1. The total costs provided is most likely to be lower due to potential crossover with current eligibility groups, and with the age bands for children potentially being further narrowed down.

53 The high-level numbers provided in Table 1 are based on certain assumptions and accurately forecasting exact number of vaccines required is difficult. There is a risk of potential vaccine wastage if predicted uptake is not achieved, and an accompanying underspend in administration costs.

Table 1: Proposed additional targeted demographic groups to access publicly funded influenza vaccinations in 2022

Targeted demographic groups	Feasibility and benefit	Implications	s 9(2)(b)(ii)
Māori and Pacific people aged 55 to 64 years old	• Māori and Pacific people experience higher rates of morbidity and mortality from influenza. • Cost has also been shown to be a barrier to getting immunised. • Allows for a whānau-centric approach which would improve uptake. • Some would already be eligible for funded vaccine.	• Embodies a whānau-centric approach and achieves equitable outcomes. • Continues to support the Ministry's equity objective and enable immunisation equity-based initiatives such as the Māori Influenza and Measles Vaccination Programme. • In line with Tiriti obligations	[redacted]
		Subtotal:	
Children aged 6 months to 17 years old	•Immunising this group has shown to better mitigate the public health risk of influenza across the entire population. •This would improve coverage in a group that are vulnerable to the severe complications of influenza •Children are more likely to spread the virus to their	•Reducing influenza transmission in the community averts many cases of severe influenza and influenza -related deaths in older people and people with clinical risk factors. •Will minimise the spread of the influenza virus, including to older people particularly	

Targeted demographic groups	Feasibility and benefit	Implications	s 9(2)(b)(ii)
	immediate household contacts. • Children under the age of 5 years have a higher risk of hospitalisation and increased morbidity after influenza and infants carry a higher burden of influenza disease. • In 2012, the UK expert committee recommended extending the influenza programme to children aged 2 to 17 years old (children 6 months to 2 years are already eligible). This has been a phased approach. For the 2021/22 winter season, free influenza vaccines will be provided to all children up to the age of 15 years.	in intergenerational households. • Extension of the influenza vaccination programme to children aims to lower the public health impact of influenza by: • providing direct protection by preventing cases of flu infection in children • providing indirect protection by lowering flu transmission from children to other children, adults and to those in the clinical risk groups of any age.	
		Subtotal:	
		Total vaccine purchase cost: Total administration cost:	
Approximate total estimated costs (assuming all demographic groups above are targeted)			

Our pathway to maximising influenza immunisation uptake will include a readiness to manage demand

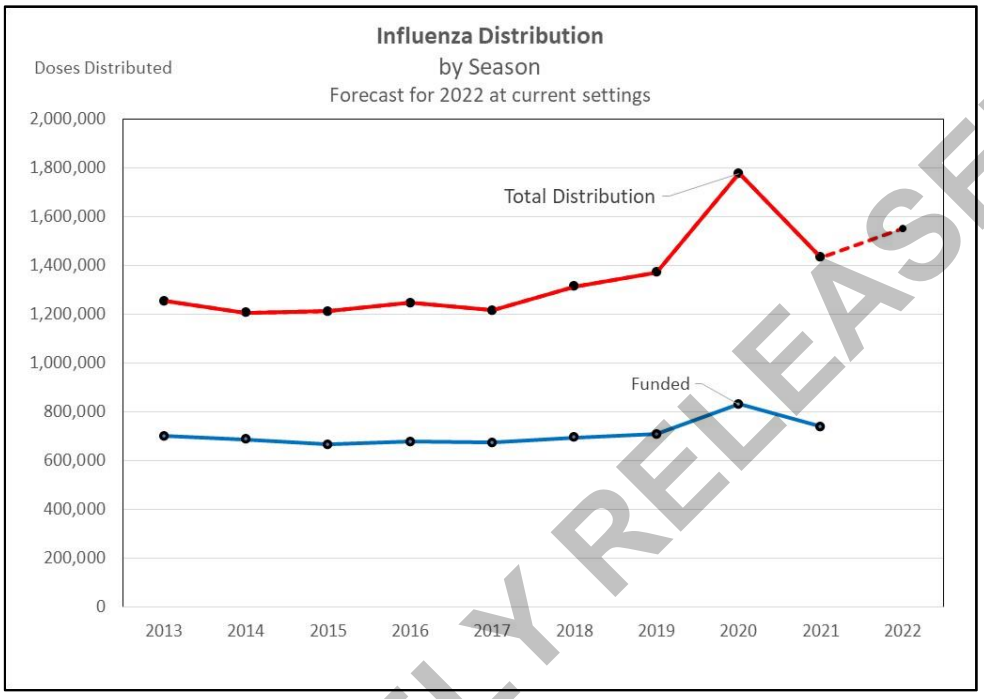
54 It is difficult to anticipate the demand for influenza vaccination to make cost-effective decisions on the influenza vaccine supply. The risk remains of over-supply, vaccine wastage and financial loss should too much be supplied, and a supply shortage should too little be supplied. We anticipate that additional stock will also need to be underwritten to manage the commercial risk of any unused vaccines at the end of the season.

55 Underwriting has recently been used to manage the commercial risk to the supplier due to demand uncertainty exceeding that anticipated when the supply agreement was reached in 2019. The supplier is obliged to ensure supply for the funded market and underwriting ensures both private and public markets are supplied with risk to the taxpayer. Continuation of improving supply and distribution remains key, particularly to mitigate the risks of supply outages as was the case in 2020.

56 Pharmac has secured 1.7 million doses, which should be sufficient to cover up to 50 percent of the eligible population and the usual privately funded market demands. Prior to 2020, the average doses secured was approximately 1.4 million and Pharmac's view is that, with the current settings, 1.55 million doses would be distributed for a "standard" influenza immunisation programme in 2022. The further 150,000 doses provide a safety buffer.

57 Figure 1 below provides an overview of the total publicly funded influenza vaccines administered since 2017 to 2021. It should be noted that the National Immunisation Register (NIR) is not a complete record of all influenza immunisations. The true number of influenza immunisations is expected to be higher and for this reason, only publicly funded vaccines, of which the Ministry has accurate data for, are shown. The gap between the two lines highlights private market demand.

Figure 1: Total publicly funded influenza vaccines administered (2017 to 2021)



58 Should demand increase, either through a change in eligibility criteria, a perceived heightened public health risk or any other reason, additional doses of influenza vaccines will be needed for 2022 and supply may not be easily accessible. Pharmac has existing relationships with multiple suppliers and has contingencies in place for seeking further stock, although the outcome of this is not guaranteed. To minimise the risks, the Ministry will work with Pharmac to model scenarios for 2022 and report back to the Vaccine Ministers with options to secure more doses of the influenza vaccines (if needed) in January 2022.

59 Initial high-level modelling, taking into consideration potentially expanding eligibility and maximising uptake alongside the COVID-19 vaccination, indicates that there will be a 46 percent increase in doses required when including Māori and Pacific people (aged 55 to 64 years old) and children (aged 6 months to 17 years) in 2022. Based on this early modelling, a total of approximately 2.5 million doses could be required for 2022. This would indicate an additional 800,000 doses to the 1.7 million already secured (See Appendix 3).

60 The Ministry and the sector will need to start planning for the 2022 influenza season as soon as possible and a decision on expanding eligibility will be needed in early January 2022 to determine whether additional doses will be required.

Implementation

61 The COVID-19 vaccination programme presents an opportunity to provide insights and resources to other immunisation programmes as part of a national immunisation approach.

62 With the pandemic, there remains uncertainty and risks which may require speedy implementation of all immunisation programmes to boost people's immunity or respond to new variants of the COVID-19 virus. Using an integrated approach will assist to streamline immunisation programmes for providers and the public through concomitantly administering immunisations where possible to maximise uptake.

63 Planning for the 2022 influenza immunisation programme in the sector has already begun. Any new policy will need to be communicated to the sector as soon as possible to ensure the programme can start by 1 April 2022 and provide the best opportunity to achieve high vaccination coverage.

64 In addition to potentially expanding the eligible groups under the influenza immunisation programme, the Ministry will focus to improve uptake through higher impact promotional campaigns, targeting parents should children be eligible for funded influenza immunisation. Lessons learnt from concomitant vaccination of immunisations alongside the COVID-19 booster programme will be drawn on to support the sector in operationalising concomitant administration of the influenza vaccination alongside the COVID-19 boosters. Given the recent Government announcements of the booster programme, the timing of the influenza immunisation seasons aligns with when the majority of the eligible population will require booster doses.

65 On 22 October 2021, Government announced the establishment of a time limited Māori Communities COVID-19 Fund (MCCF) to support Māori, iwi and community providers to increase Māori vaccinations uptake and accelerate their current responses and build resilience. The MCCF complements work within the vaccine programme and the wider COVID-19 response rather than duplicate existing activities. Adopting an integrated approach to all immunisation programmes while continuing to achieve its equity goals as part of its overall COVID-19 response will be critical for the successful use of the fund.

Financial Implications

66 Proposals presented in this paper will require additional funding and drawdown of tagged contingency.

67 Current COVID-19 vaccine programme forecasts have identified that not all of the current allocated tagged contingency will be required to complete the first phase of the programme.

	$ millions
CAB-21-MIN-0229 contingency established	$1,756.980
Appropriated Funds	- $1,387.606

Purchase contingency	$500.000
s 9(2)(f)(iv)	[redacted]
Drawdown of tagged contingency 22 October 2021	- $100.000
s 9(2)(f)(iv)	[redacted]

68 Based on the current Programme forecast we are expecting s 9(2)(f)(iv) to remain within the 'Minimising the health impacts of COVID-19 – Tagged Operating Contingency' to contribute to funding part of the next phase of the vaccination campaign.

69 s 9(2)(f)(iv) is estimated to be required for the remainder of the first phase of the programme rollout to be drawn down through this paper.

70 As outlined in Table 2 below, Cabinet's approval is sought to approve a further s 9(2)(f)(iv) to cover the anticipated cost of the COVID-19 vaccination programme, including the:

70.1 delivery of the COVID-19 booster programme to every eligible person

70.2 delivery of primary COVID-19 immunisations to children aged from 5 to 11 years old inclusive (pending approval)

Table 2: Additional funding required by activity area

Cost breakdown based on activity area	**Additional in 2021/22**
	$ million
s 9(2)(f)(iv)	[redacted]

Cost breakdown based on activity area	Additional in 2021/22
	$ million
s 9(2)(f)(iv)	[redacted]

71 Given an initial order for the influenza vaccine in 2022 has already been placed based on volumes purchased in previous years, the Ministry will work with Pharmac to procure additional vaccine either from the current supplier or alternate suppliers (if needed) subject to further advice to Vaccine Ministers.

72 You are asked to delegate authority to Vaccine Ministers to drawdown from the COVID-19 Response and Recovery Fund for costs related to expanding influenza programme for 2022, subject to further analysis on likely demand, implementation plans, and costs of purchase and roll-out.

Legislative Implications

73 There are no legislative implications for this proposal.

Regulatory Impact Analysis

74 The proposal in this paper does not require a Regulatory Impact Statement on the grounds that it is does not have any legislative impacts.

Population Implications

75 The COVID-19 vaccination programme has further highlighted the known inequities in the health system, and the challenges many people in New Zealand face in accessing health services. There is a significant equity gap between coverage for Māori and Pacific people, and coverage for non-Māori, non-Pacific. This gap is present across the immunisation programmes.

76 The proposals in this paper will provide greater protection for population groups at high risk, particularly Māori, Pacific people and disabled people, from vaccine preventable diseases, including COVID-19.

Population group	How the proposal may affect this group
Māori	Māori experience higher rates of morbidity and mortality from vaccine preventable diseases and historically have lower rates of immunisation. Māori need to be prioritised based on increased vulnerability to infection, being more likely to be part of the essential workforce and living in intergenerational households. Cost has also been shown to be a barrier to getting immunised. The cost to vaccinate Māori will be higher due to the additional barriers that are present (i.e., health literacy, trust in

Population group	How the proposal may affect this group
	the systems, co-morbidities, underlying health conditions and access issues, workforce of Māori health providers). Doing more of the same would not be effective in eliminating inequities. Eliminating the cost barrier for this group, alongside targeted implementation, would improve their vaccine uptake. This would be a step to directly address health inequities experienced by Māori. Work is underway to ensure kaupapa Māori immunisation services are available.
Pacific people	Pacific people also experience higher rates of morbidity and mortality from vaccine preventable diseases. As with Māori, immunisation for Pacific people need to be prioritised. Cultural factors, cost and language are potential barriers to immunisation. Equitable delivery of the immunisation which is culturally appropriate should be a focus for Pacific people.
Older people	Protection received by older people from earlier immunisations begins to wear off and their immune system may no longer work as well and are at increased risk from some infectious diseases. Older people living in long-stay residential care homes or other long-stay care facilities are also more at risk where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. Mortality is significantly higher in older people than younger healthy adults.
Disabled people	Disabled people are vulnerable to complications from vaccine preventable diseases. Equitable access to immunisations remains important for disabled people.
Pregnant people and children	Immunisations for pregnant people and children provide the best protection against common infectious diseases. For pregnant people, immunisations provide additional protection for newborn babies who cannot be directly vaccinated. Immunisation of healthy children has the potential to reduce illnesses and related costs in both children and their families.

Te Tiriti o Waitangi implications

77 There continues to be a focus on increasing vaccination uptake for Māori. In the past, and particularly throughout the COVID-19 response, iwi, hapū and whānau have exercised, and in many cases exceeded, good practice in line with government guidelines to maintain the wellbeing of their own whānau.

78 The proposals in this paper support health system resilience, maintain community protection. This is critical to minimising and addressing existing inequities and is consistent with Te Tiriti principle of active protection.

Human Rights

79 There are no human rights implications arising from the recommendations in this paper as the recommendations reduce the likelihood of discrimination against certain groups.

Consultation

80 The following agencies have been consulted in the preparation of this Cabinet paper, namely, the Treasury, the Department of the Prime Minister and Cabinet (DPMC), Te Puni Kōkiri, Te Arawhiti and Pharmac.

Treasury comment

81 The Treasury supports providing the necessary level of funding to ensure the COVID-19 vaccine programme and influenza programme run successfully in 2022 and to ensure that funding availability does not lead to delivery delays. The analysis in this paper had not progressed substantially over the past few months but following consultation with the Ministry of Health, the administration costs were dropped to s 9(2)(f)(iv)

82 We support this revised amount of s 9(2)(f)(iv) but still do not feel confident about the appropriateness of the costings for both the COVID-19 vaccination programme and the influenza immunisation programme, particularly given the potential for achieving efficiencies in a second year of delivery and being able to co-deliver the COVID-19 vaccine and influenza vaccine. We recommend Ministers request regular reporting on vaccine programme actual costs and adjust funding as necessary.

83 Additionally, we have not seen sufficient information to understand how additional demand will be created for the expanded influenza programme in 2022 and recommend Ministers request further information before agreeing to any drawdown of funding for an expanded campaign.

Communications

84 Officials will prepare material to support communication with key stakeholders and the sector. Clear communication is important to work towards an integrated immunisation approach delivering on population protection and to maximise uptake through the various immunisation programmes.

Proactive Release

85 This Cabinet paper will be released in accordance with the normal processes with redactions as appropriate under the Official Information Act 1982.

Recommendations

The Minister of Health and the Minister for COVID-19 Response recommend that the Committee:

1 **note** that reopening New Zealand's borders raises the risk of an increase in vaccine preventable diseases, particularly when immunisation rates are low

2 **endorse** the direction of the strategic approach to immunisation, which aims to ensure immunisations are prevention focused, responsive, easily accessible and equitable in improving health outcomes for all New Zealanders

Continuing the COVID-19 vaccination programme into 2022 and transitioning to an integrated national immunisation programme

3 **note** the COVID-19 vaccination programme provides the basis for an integrated national immunisation approach to deliver greater population protection as we reconnect New Zealand

4 **note** the system immunisation priorities over the next nine months to June 2022 as indicated in paragraph 23 of this paper

5 **note** that on 15 November 2021 Cabinet agreed to proceed with the COVID-19 booster programme which commenced on 29 November 2021 [CAB-21-MIN-0475]

6 **note** the full fiscal implications of delivering the COVID-19 booster programme and delivery of COVID-19 vaccines to children aged from 5 to 11 years old remains uncertain but the current estimation is that at least an additional s 9(2)(f)(iv) is required

7 **note** that the administration of the COVID-19 vaccine to children aged from 5 to 11 years old is expected to start around the end of January 2022, subject to regulatory approval

8 s 9(2)(f)(iv)

9 **note** that COVID-19 vaccines will continue to be funded separately from the Combined Pharmaceutical Budget and Ministers will continue to approve final decisions on purchases

10 **direct** the Ministry of Health to report back in February 2022 s 9(2)(f)(iv)

11 **direct** the Ministry of Health and Pharmac s 9(2)(f)(iv)

12 s 9(2)(f)(iv)

Decisions on an expanded influenza immunisation programme with a broader eligible population

13 **note** eligibility for free influenza vaccination is currently targeted to protect those at greatest risk of serious risk from influenza and who will receive the most benefit

14 **note** that Pharmac and Seqirus have agreed on the supply of 1.7 million doses of influenza vaccines for 2022 which is intended to supply both the public and private market

15 **note** that expanding the influenza programme and the eligible population will require additional doses of the influenza vaccine

16 **note** that Pharmac has advised that vaccine availability is uncertain at this late stage in the global manufacturing allocation process

17 **agree** in principle to the expanded influenza programme for 2022, given the high public health risk in anticipation of borders reopening, to include:

17.1 the Ministry to work in partnership with Pharmac to consider a broader eligible population

17.2 a focus on maximising uptake through broad and targeted communication and engagement, a strengthened vaccinator workforce and proven service delivery models that have made vaccination easy and accessible

17.3 strengthening programmes and approaches to support equitable uptake including the Māori Influenza and Measles Vaccination Programme

18 **direct** the Ministry of Health to report back in early 2022 to Vaccine Ministers with further information on modelling, including cost and implications ahead of the start of the programme in April 2022 including what will be done to improve uptake

19 **authorise** the Prime Minister, the Minister of Finance, the Minister of Health and the Minister for COVID-19 Response to jointly approve the draw down of funding from the COVID-19 Response and Recovery Fund for costs related to expanding influenza programme for 2022, subject to further analysis on likely demand, implementation plans, and costs of purchase and roll-out

Financial implications

20 **note** that the anticipated cost of the COVID-19 vaccination programme in 2022 is s 9(2)(f)(iv)

21 **agree** to additional funding of s 9(2)(f)(iv) in 2021/22 to support the COVID-19 vaccination programme as a call against both the COVID-19 Tagged – Operating Contingency and the COVID-19 Response and Recovery Fund, with the following impacts on the operating balance and net core Crown debt:

	$m - increase/(decrease)				
Vote: Health Minister of Health Minister for COVID-19 Response	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26 & Outyears**
s 9(2)(f)(iv)					

s 9(2)(f)(iv) [redacted]

22 **approve** the following changes to appropriations to provide for the decision in recommendation 21 above:

	$m - increase/(decrease)				
	2021/22	**2022/23**	**2023/24**	**2024/25**	**2025/26 & Outyears**
Vote: Health **Minister for Health**					
s 9(2)(f)(iv) [redacted]					

23 **agree** that the proposed changes to the appropriations for 2021/22 above be included in the 2021/22 Supplementary Estimates and that, in the interim, the increases be met from Imprest Supply

24 **agree** that s 9(2)(f)(iv) [redacted] of the funding sought in recommendation 21 above be charged as a call against the COVID-19 – Tagged Operating Contingency, with a corresponding impact on the operating balance and net core Crown debt

25 **agree** that s 9(2)(f)(iv) [redacted] of the funding sought in recommendation 21 above be charged as a call against the COVID-19 Response and Recovery Fund, with a corresponding impact on the operating balance and net core Crown debt

26 **note** that the appropriation Minister of Health and the Minister of Finance agree that any movement of amounts between categories in the above multi-category appropriation must reflect any changes in the agreed approach taken to address the COVID-19 public health response and cannot be applied to any other Health related initiatives.

Authorised for lodgement

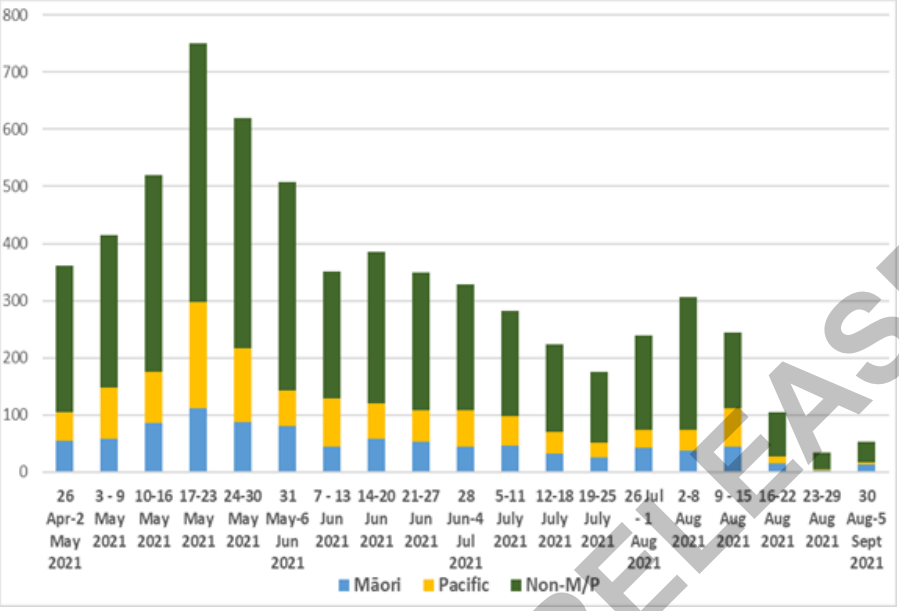
Hon Chris Hipkins
Minister for COVID-19 Response

Hon Andrew Little
Minister of Health

Appendix 1 – Overview of Measles and Childhood immunisations

Measles Immunisations

Figure 1: Count of measles vaccinations given per week April to September 21



Childhood immunisations

The table below show an overall decrease in national coverage across each of the three milestones and an equity gap for tamariki Māori/Pacific children.

Table 1. National child immunisation coverage by milestone and ethnicity

Milestone	Total		NZ European		Māori		Pacific	
	Q3	Change from Q2	Q3	Change from Q2	Q3	Change from Q2	Q3	Change from Q2
8 months	87.7%	-1.5%	90.5%	-1.5%	75.8%	-1.9%	86.1%	-4.7%
24 months	88%	-1.8%	90.2%	0.6%	78.8%	-3.3%	85.9%	-5.2%
5 years	85.4%	-1.7%	87.6%	1.5%	78.2%	-2.4%	84.2%	-3.8%
	Q4	Change from Q3	Q4	Change from Q3	Q4	Change from Q3	Q4	Change from Q3
8 months	87.3%	-0.4%	90.2%	-0.2%	85.3%	-0.7%	85.3%	-0.7%
24 months	85.4%	-2.6%	88.9%	-1.4%	72.5%	-6.3%	82.3%	-3.6%
5 years	85.0%	-0.4%	87.3%	-0.3%	77.4%	-0.8%	84.8%	0.6%

s 9(2)(g)(i)

[redacted]

s 9(2)(g)(i)

[redacted]

Appendix 3 – High level forecasting: Potential additional doses required for influenza vaccinations in 2022 (if eligibility groups are expanded)

Age Groups	HSU population 2020	Estimated additional uptake across age groups for 2022	Doses secured for 2022	Total doses potentially needed for 2022	% change
Māori and Pacific people (aged 55-64 years) and children aged 5 to 11 years	574,531	314,000	1,700,000	2,014,530	19%
Māori and Pacific people (aged 55-64 years) and children aged 6 months to 5 years	421,678	224,365	1,700,000	1,924,365	13%
Māori and Pacific people (aged 55-64) and children aged 6 months to 17 years	1,275,380	774,192	1,700,000	2,474,192	46%

The assumptions for the above are as follows:

- The Health Service User (HSU) population, as used for vaccine uptake monitoring
- Estimate influenza vaccine uptake based on the 1.7 million doses plus the additional uptake by proposed additional groups
- Estimated additional uptake across age groups for 2022 is based on the HSU population estimate minus an estimate of those with Long Term Conditions and the assumption of uptake equivalent to COVID-19 vaccine uptake for these groups
- Uptake estimates for these groups removes potential people with Long Term Conditions as they would be considered to be eligible under the current criteria already
- Uptake of the COVID-19 vaccination (first dose) until the week ending 31 October 2021
- The assumption for uptake of vaccination for the child group is based on recent Horizon polls where parents or caregivers of children aged 5 and over have indicated that they would most likely vaccinate their children with the COVID-19 vaccine although we assume the uptake for children in the <5 to 11 age group would be lower.

Appendix 4 – COVID-19 Vaccination Programme 2022: Breakdown of costs

	Total doses	s 9(2)(j) [redacted]
COVID-19 vaccine for children aged from 5 to 11 years old (2 doses each)	934,008	
Aging into eligibility first half 2022 (children aged from 4 to 5 years old) (2 doses each)	60,182	
Returnees	75,000	
Boosters for NZ population (1 dose, ages 12+)	4,408,849	
Total	**5,478,039**	