CAB-23-MIN-0055

Cabinet

Minute of Decision

Report of the Cabinet Social Wellbeing Committee: Period Ended 24 February 2023

On 27 February 2023, Cabinet made the following decisions on the work of the Cabinet Social Wellbeing Committee for the period ended 24 February 2023:

Out of scope	[redacted]	[redacted]
Out of scope	[redacted]	[redacted]
Out of scope	[redacted]	[redacted]
SWC-23-MIN-0006	**COVID-19 Public Health Measures** Portfolio: Health	CONFIRMED
Out of scope	[redacted]	[redacted]

Rachel Hayward
Secretary of the Cabinet

Cabinet Social Wellbeing Committee

Minute of Decision

COVID-19 Public Health Measures

Portfolio **Health**

On 22 February 2023, the Cabinet Social Wellbeing Committee:

1 **noted** that since October 2022, New Zealand has had the following COVID-19 requirements in place:

1.1 seven-day mandatory self-isolation for cases;

1.2 government-mandated mask requirements for visitors to certain healthcare services, including pharmacies but not counselling services;

2 **noted** that an authorisation under 8(c) of the COVID-19 Public Health Response Act 2020 (the Act) enables the making of COVID-19 orders for self-isolation of cases and masks for visitors to health care settings;

3 **noted** that the Prime Minister has received advice to extend the expiry date of this authorisation to 28 April 2023;

Review of case isolation requirements

4 **agreed** that, for self-isolation of cases, to retain the status quo of seven-day mandatory self-isolation (Director-General of Health recommended);

Review of government mandated mask requirements

5 **agreed** to retain government-mandated mask requirements for visitors to healthcare services (Director-General of Health recommended);

Next steps

6 **noted** that COVID-19 response settings will be reviewed again in March 2023.

Rebecca Davies
Committee Secretary

Attendance: see over

Present:
Rt Hon Chris Hipkins
Hon Carmel Sepuloni (Chair)
Hon Jan Tinetti
Hon Dr Ayesha Verrall
Hon Willie Jackson
Hon Priyanca Radhakrishnan
Hon Kieran McAnulty
Hon Ginny Andersen
Hon Rino Tirikatene
Jo Luxton MP

Officials present from:
Office of the Prime Minister
Office of the Chair
Officials' Committee for SWC

In Confidence

Office of the Minister of Health

Cabinet Social Wellbeing Committee

COVID-19 public health measures

Proposal

1. This paper proposes to continue the current mandatory public health measures relating to COVID-19.

Relation to government priorities

2. This paper concerns the Government's response to COVID-19.

Executive Summary

3. While key measures of COVID-19 infection are currently decreasing in most regions, there remains some uncertainty regarding whether this will continue when schools reopen and mixing patterns return to more typical levels.

4. The current set of public health measures – both mandatory and non-mandatory – form a pragmatic approach to managing COVID-19. These measures include:

    4.1 deliberate action to encourage take up of primary courses and boosters of COVID-19 vaccines, to ensure as many eligible people are up to date as possible, to maintain high levels of immunity;

    4.2 a system of care to help people to safely manage their symptoms at home, as far as possible, and to support people at greater risk of serious illness to access antiviral medications in a timely manner;

    4.3 requiring cases to isolate for 7 days;

    4.4 encouraging household contacts and people who are symptomatic to test, through the distribution and supply of rapid antigen tests (RATs);

    4.5 encouraging and supporting use of medical grade masks, including by people at greater risk of serious illness and in higher risk settings, and requiring use of masks by visitors to health services;

    4.6 tailored communications across channels and communities to support and reinforce good public health behaviours;

    4.7 surveillance of COVID-19 prevalence including whole genome sequencing to identify new subvariants.

5. Several of these measures require the use of COVID-19 orders to create the legal requirements and restrictions. The Director-General of Health (the Director-General) and her team have completed a public health risk assessment based on the current context and recommended the existing COVID-19 public health measures be retained, including:

    5.1 mandatory use of masks for visitors to health services

    5.2 mandatory isolation of cases for 7 days

    5.3 regulation of the import, manufacture and supply of point-of-care tests.

6. I support these proposals and consider these measures are the minimum necessary to minimise the impact of COVID-19.

7. The principle of proportionality is a key consideration. In assessing proportionality, it is important to account for both Tiriti o Waitangi and equity considerations as more restrictive measures may be required to achieve these objectives.

8. I recommend maintaining the current mandatory measures. It is likely that cases will rebound to some extent, as people resume to work, study and public transport. The current mix of variants in the community adds further uncertainty. In this context, the mandatory measures remain necessary to reduce transmission, to protect people at greater risk of serious illness and to protect the health system. These measures continue to play a critical role to help keep the COVID-19 outbreak under control.

Context

Status of the COVID-19 outbreak

9. Overall, the key measures of infection used to monitor the COVID-19 epidemic continue to decrease in most regions after peaking in mid-December. Modelling undertaken in late 2022 suggests that this trend will continue, but the usefulness of modelling is limited due to factors such as variants, vaccines and antivirals. Case rates are currently similar to the low rates between the August and December COVID-19 waves.

10. Hospital admission rates have also decreased since the start of 2023, while mortality counts are tracking well below the expected modelling. Between 1 January 2022 and 16 January 2023, 63% of hospital admissions involving patients with COVID-19 were patients coming in for COVID-19 related illness rather than incidentally having COVID-19, reflecting the pressure COVID-19 continues to place on the health system. There were 25,706 hospital admissions for COVID-19 during this time period.

Variants

11. There are multiple variants in the community, with no one variant being dominant.

11.1 The most common variant is CH.1.1, which is a sub-lineage of BA2.75, and now accounts for 38% of cases in the community.

11.2 The next most prevalent are XBF at 15% of community cases, BA.2.75 at 15%, and BQ1.1 at 9%. BA.5, which was the dominant variant for most of 2022, has been steadily declining since November and now only accounts for 8% of total cases.

11.3 XBB.1.5 (referred to as 'Kraken' in the media) has not currently taken hold in New Zealand as it has in the United States (US). In the US, XBB.1.5 has increased growth advantage over new variants and there is a concern that this could become the new dominant strain of COVID-19 in New Zealand. It is notable that New Zealand has a different immune landscape to the US and so far, XBB (which XBB.1.5 is a subvariant) only accounts for 3% of total cases.

Impact

12. There are still significant differences in the rate of severe illness from COVID-19 amongst ethnic groups. Based on comparison of age-adjusted rates, worst affected are Pacific people, who are 2.3 times more likely than the 'European and other' classification to be hospitalised with COVID-19, with Māori the next worst affected at 1.8 times more likely to be hospitalised with COVID-19. Recent hospitalisation data show Pacific people were at considerably higher risk of hospitalisation over December. In the week ending 16 January Māori had the highest age adjusted admission rate (1.7 per 100,000). Disability Support Service recipients had 4 times the risk of hospitalisation compared to the rest of the population during 1 January - 16 November 2022 (noting that not all disabled people are clients of DSS).

13. Older people are more likely to have severe illness than younger people. People aged 50 years and above have accounted for 626,048 cases (29% of total cases), of whom 2,440 have died (98% of total deaths) in the period to 29 January 2023.

14. The proportion of cases that are reinfections has increased steadily since late 2022. Reinfections currently account for just under 40% of reported cases overall, and 60% of cases reported for people aged 20-29 years.

15. While vaccination and use of antivirals reduce the risk of severe disease in the acute phase of illness, the number of people affected by severe disease remains high relative to other causes. For example, in 2022 there were 2,319 deaths attributable to COVID-19 in New Zealand. This is approximately six times more than the number of people killed on the roads in 2022 (378), and just under two times the number of annual deaths due to colorectal cancer (approximately 1,200). For all cases reported to 29 January 2023, these impacts include a total of 25,778 hospitalisations for COVID-19, and 3,781 deaths within 28 days of being reported a case.

16. The Director-General reports that based on evidence from overseas, 3-10% of cases may develop long COVID, of whom 20% may have ongoing significant

disability. Long COVID and other post-acute conditions have costs to individuals and whānau, costs to government (welfare and health), but also broader impacts on society, such as reduced workforce participation and productivity.

Current measures

17. In December 2022, in the context of rising case numbers, Cabinet agreed to continue the following COVID-19 mandatory public health measures:

    17.1 7-day self-isolation for cases; and

    17.2 mask requirements for visitors to healthcare services [CAB-22-MIN-0581].

18. In addition, the import, manufacture and supply of point-of-care tests is regulated. The use of orders for these purposes is authorised by the COVID-19 Public Health Response (Authorisation of COVID-19 Orders) Notice 2022, made by the Prime Minister under section 8(c) of the COVID-19 Public Health Response Act 2020 ('the Act').

19. A public health risk assessment was carried out on 26 January 2023 to review the appropriateness of settings to respond to the current outbreak (see Appendix One). This process leads to the development of public health advice from the Director-General, which supports the requirement under section 14(5) of the Act for the Minister to keep all mandatory measures under review. The Director-General's recommendations are set out in this paper.

Vaccination

20. This week I received advice on the bivalent vaccine (decision-to-use), including booster eligibility.

Antivirals

21. Ensuring that people at higher risk of severe disease have access to antivirals remains a key element of the response. Antivirals reduce the risk of severe disease, but need to be taken within 5 days of a person becoming symptomatic. In 2022 eligibility for antivirals was significantly expanded by Pharmac, regulations now permit Pharmacist-Only Supply, and public messaging has been targeted to eligible groups.

Self-isolation

22. Officials have analysed options for self-isolation for cases:

    22.1 Retain the status quo of 7-day mandatory self-isolation; or

    22.2 Reduce the self-isolation requirement to 5-day mandatory self-isolation, followed by test-to-release; or

22.3 Case isolation requirements are removed and replaced with a clear instruction from their health provider to remain at home for as long as they remain symptomatic. Compliance would be voluntary to both the self-isolation requirement and such an instruction from the person's GP (or similar).

23. In October 2022, I advised that 7 days is likely the minimum threshold for self-isolation to remain an effective intervention. Public health advice is that a shorter isolation period, combined with test-to-release, is not considered a viable way to achieve the health objective in the current context of a significant degree of uncertainty due to waning immunity, variant impact and behavioural change.

24. A mandatory requirement for 5-day isolation would not be an effective intervention, as infectious viral load has shown to be still high for Omicron on day 5. While there has been a reduction in isolation requirements over the course of the outbreak, we have reached what is probably the minimum threshold for self-isolation of cases to remain effective. The option to reduce the mandatory period of isolation to 5 days has therefore not been reconsidered in this paper.

Public health advice

25. The Director-General recommends that the current government mandated 7-day case isolation requirement is retained.

26. Case isolation is one of the cornerstone measures of New Zealand's public health response to COVID-19. This measure significantly limits transmission of COVID-19 by reducing the proportion of infectious people having contact with and infecting others in the community, including vulnerable populations. Without government mandated case isolation, it is highly likely that adherence to guidance would be lower, resulting in an overall increase in transmission and case rates.

27. Evidence from a United Kingdom study suggests that a legal requirement to isolate results in significantly greater adherence than a recommendation to isolate. Experience when other mandates have been removed in New Zealand reinforces the fact that adherence to guidance is typically much lower than to mandates.

28. In New Zealand, results from the most recent behavioural research survey suggest the current self-isolation requirement remains effective, with relatively high levels of compliance. In a survey of 1,393 adults undertaken by Horizon Research 1-7 November 2022 (commissioned by Manatū Hauora):

28.1 92% of people who tested positive reported at least one test on MyCovidRecord;

28.2 78% of people who tested positive in the previous 2 weeks, isolated for the full seven days; and

28.3 85% of people said they were very likely or likely to isolate if they tested positive in future.

29. Modelling on current mandatory case isolation indicates that:

29.1 if current measures are retained, the daily hospital occupancy will reach between 250 to 300 beds occupied daily over the next 2 months;

29.2 a change to case isolation requirements that results in an increase in the rate of transmission by 7.5%, will cause an approximate 50% increase in peak bed occupancy in hospitals in the 2 months following the change and will reach between 375 and 450 beds occupied daily; and

29.3 a change in case isolation requirements that results in an increase in the rate of transmission by 10% will cause an approximate 70% increase in peak bed occupancy in hospitals over the 2 months following the change and will reach between 400 and 475 beds occupied daily.

Population and sector impacts

30. The Director-General notes that it is likely that removing case isolation would result in an increase in cases in some communities and population groups more than others. There is an acknowledged differential exposure to COVID-19 risk related to socioeconomic status.

31. People in lower socioeconomic groups are more likely to work in jobs with greater risk of exposure, to live in larger and typically more crowded houses, and to have underlying risk factors. If there are more infectious people circulating in a community with more baseline contacts, this increases the likelihood of onward transmission.

32. If the isolation mandate was removed, employees may be pressured to return to work even if they are not fully recovered. Equity issues are central to this concern, particularly what this change might mean for Māori and Pacific communities.

33. The Crown's obligations to Māori under Te Tiriti o Waitangi require active protection of taonga and a commitment to partnership that includes good faith engagement with and appropriate knowledge of the views of iwi and Māori communities. The active protection principle obliges the Crown to take all steps practicable to protect Māori health and wellbeing, and to support and resource Māori to protect their own health and wellbeing. This includes efforts to counteract inequitable health outcomes and prevent the impact of COVID-19 from falling disproportionately on Māori.

34. Other population and sector impacts include:

34.1 Te Arawhiti, Te Puni Kokiri, Ministry for Pacific Peoples, Whaikaha, Oranga Tamariki, and the Department of Corrections explicitly supported continuation of the requirement to isolate. Each agency has

noted the ways in which their respective population groups were more vulnerable, and concern at the potential impact of removing isolation.

34.2 The Ministry of Education noted that it supported decisions relating to isolation continuing to be health-led. They also advise that tertiary providers are mindful of their health and safety obligations and would prefer not to impose their own restrictions if there were no government requirements in place. Providers have indicated that they would prefer to have a clear government mandated restriction for longer, than to have frequent changes or have to impose their own restrictions.

34.3 The Ministry for Ethnic Communities did not explicitly support a particular option but noted potential benefits and concerns. The Ministry of Housing and Urban Development noted a concern in relation to the possibility that increased cases might place further pressure on northern region providers.

34.4 The Ministry of Transport has provided feedback that case isolation requirements are impacting on existing workforce shortages across the aviation sector which are already under significant pressure. The recent weather events in Auckland have resulted in additional significant disruptions to the aviation system.

35. See Appendix Two for further details of each item above.

Economic impacts

36. The Treasury notes the feedback from the Ministry of Transport and the Ministry for Ethnic Communities regarding the difficulties businesses are experiencing because of COVID-19 and continued isolation requirements. Removing mandatory case isolation may provide an economic benefit compared to the status quo by reducing unnecessary isolation days and easing businesses' staffing shortages in a tight labour market. Any positive economic impact will be small if compliance with the current requirement is already low. Survey and wastewater data have suggested there has been a significant decline in testing and/or the reporting of positive test results over time.

37. The Treasury notes that potential countervailing factors, which are difficult to quantify, include:

37.1 The extent to which people are well enough to work for some or all the relevant period

37.2 An increase in overall infections causing additional people to be too unwell to work. Previous modelling has suggested that the requirement to isolate is only having a small impact on overall infections, particularly over the long-term (and as a result, the prevalence of post-acute conditions like Long COVID). In addition, modelling has suggested that due to waning population immunity, removing the isolation requirement

later may result in a higher case peak and therefore have a larger workforce impact.

Self-isolation support schemes

38. The existing isolation requirements are supported by two schemes: the Leave Support Scheme (LSS) and the Care in the Community (CIC) welfare response. LSS has a significant ongoing fiscal cost, while the CIC welfare response can be met within the current allocated funding, which is time-limited until the end of the financial year.

Leave Support Scheme (LSS)

39. The cost of the LSS has reduced in line with the reduction in case numbers, with around $27.5 million paid out in January 2023 (compared to $180 million paid out in March 2022). Since late November 2022, cases have averaged around 3,800 per day, while spending, on average, $6.5 million per week on the scheme. At this rate, current approved funding will run out around the end of the financial year if mandatory case isolation and the LSS remains in place. Ending the LSS now would result in around $100 million being returned to the centre.

40. The Treasury and MSD will report to the Minister of Finance and the Minister for Social Development and Employment in March 2023 on options for further funding if the scheme remains operational.

Care in the Community welfare response (CIC)

41. The CIC welfare response includes critical food support, Community Connectors, support for households with broader COVID-related issues, support for disabled communities, personal protective equipment (PPE) for at-risk communities, support for RLGs and broader system business as usual welfare and income supports.

42. If mandatory case isolation is removed altogether, CIC food supports would cease. MSD anticipates that there would be increased uptake of MSD business-as-usual baseline supports as a result of this change. At the October Baseline Update, Ministers carried forward an additional $13 million for CIC in 2022/23 and confirmed that the ongoing cost to CIC welfare responses - Food Secure Communities and Community Connectors – can be met within current allocated funding. Funding is time-limited until 1 July 2023.

National Alternative Accommodation Service (NAAS)

43. The NAAS provides accommodation support to those unable to isolate at home or where they are currently located. There would be operational implications relating to the NAAS if self-isolation requirements are continued, which are being addressed in separate advice to Ministers.

Point of care tests

44. It is also appropriate to maintain the regulation of RATs (point-of-care tests) while mandatory self-isolation requirements are in place. The importation, manufacture, supply, sale, packaging, and use of point of care tests is regulated under the COVID-19 Public Health Response (Point-of-care Tests) Order 2021. The purpose of this order is to ensure RATs, relied on to establish whether a person is subject to mandatory self-isolation, are accurate and reliable.

Masks

45. Mask requirements are set out in the COVID-19 Public Health Response (Masks) Order 2022 (the Masks Order). The Masks Order specifies that masks are legally required for visitors to a wide range of healthcare services including pharmacies.

46. There are exclusions for patients and people receiving residential care, health service staff, and visitors to specific health services (for example, psychotherapy, counselling, mental health, and addiction services). Requirements for patients and workers are determined by the health service, based on local assessments in line with Infection Prevention and Control guidance.

47. I recommend retaining the status quo, that is the government mandated mask requirements for visitors to health service settings.

Public health advice

48. The Director-General recommends retaining mask requirements for visitors in health service settings. These mask requirements ensure that people who are at higher risk of severe illness can access healthcare in a relatively safe way without avoidable additional risk.

Economic impacts and operational considerations

49. The Treasury does not consider that current mask requirements have any measurable economic impact. There are no operational considerations to note.

Consultation

50. This paper was prepared by Manatū Hauora. The following agencies were also consulted, and their views are reflected throughout this paper: The Department of the Prime Minister and Cabinet, Crown Law Office, New Zealand Customs Service, Department of Internal Affairs, Department of Corrections, Ministry of Business, Innovation, and Employment, Ministry for Culture and Heritage, Ministry of Education, Ministry for Ethnic Communities, Ministry of Foreign Affairs and Trade, Ministry of Housing and Urban Development, Ministry of Justice, Ministry for Pacific Peoples, Ministry for Primary Industries, Ministry of Social Development, Ministry of Transport, Oranga Tamariki, Parliamentary Counsel Office, Police, Public Service

Commission, Te Aka Whai Ora, Te Arawhiti, Te Puni Kōkiri, Te Whatu Ora, the Treasury, Whaikaha – Ministry of Disabled People, and the Office for Seniors.

Financial Implications

51. Financial implications have been included in relevant sections of the paper.

Legislative Implications

52. If current settings for self-isolation and masks are retained, there are no legislative implications for the Self-isolation Order or the Masks Order.

53. It is also appropriate to maintain the regulation of RATs (point-of-care tests) while mandatory self-isolation requirements are in place. The importation, manufacture, supply, sale, packaging, and use of point of care tests is regulated under the COVID-19 Public Health Response (Point-of-care Tests) Order 2021. The purpose of this order is to ensure RATs, relied on to establish whether a person is subject to mandatory self-isolation, are accurate and reliable.

54. In December 2022, the COVID-19 Public Health Response (Authorisation of COVID-19 Orders) Notice 2022 came into force, by which the Prime Minister authorised the use of COVID-19 orders in relation to self-isolation requirements for COVID-19 cases, regulation of RATs (point-of-care tests), and mask requirements in health service premises. This notice expires on 28 February 2023. The Prime Minister will be receiving advice regarding the extension of the authorisation before 20 February 2023.

Impact Analysis

55. A Regulatory Impact Statement has been completed and is attached as Appendix Three. Manatū Hauora's Papers and Regulatory Committee has reviewed the attached Regulatory Impact Statement and is satisfied that it Meets the quality assurance criteria.

Population Implications

56. Please refer to Appendix Two.

Human Rights s 9(2)(h)

s 9(2)(h)

57. s 9(2)(h)

58. s 9(2)(h) [redacted]

59. s 9(2)(h) [redacted]

s 9(2) [redacted]

60. s 9(2)(h) [redacted]

Communications

61. I will announce Cabinet's decisions on this paper during the week of 27 February 2023.

Next steps

62. Unless there is a significant change in COVID-19 risk, any remaining government-mandated measures will be reviewed again in March 2023. Manatū Hauora will report back to the Minister of Health on the results of that review, and to Cabinet if major changes are proposed.

Proactive Release

63. This paper will be proactively released following Cabinet consideration.

Recommendations

The Minister of Health recommends that the Committee:

1. note that since October 2022, we have had the following COVID-19 requirements in place:

    a. Seven-day mandatory self-isolation for cases; and

b. Government-mandated mask requirements for visitors to certain healthcare services, including pharmacies but not counselling services;

2. note that there is an authorisation under 8(c) of the COVID-19 Public Health Response Act 2020 (the Act) in place to allow for the making of COVID-19 orders for self-isolation of cases and masks for visitors to health care settings until 28 February 2023;

3. note that the Prime Minister will receive advice before 20 February 2023 on extending the expiry date beyond 28 February 2023;

Review of case isolation requirements

4. agree, for self-isolation of cases to retain the status quo of 7-day mandatory self-isolation (Director-General of Health recommended);

Review of government mandated mask requirements

5. agree to retain government mandated mask requirements for visitors to healthcare services (Director-General of Health recommended);

Next steps

6. note that decisions on this paper will be announced during the week of 27 February 2023;

7. note that COVID-19 response settings will be reviewed again in March 2023.

Authorised for lodgement

Hon Dr Ayesha Verrall

Minister of Health

Appendix 1: Public health advice from the Director-General of Health (attached)

Appendix 2: Population Implications

64. As I have previously advised, the burden of COVID-19 does not fall equally, and changes to protective measures could disproportionately affect population groups such as older people, disabled people and tāngata whaikaha Māori, Māori, Pacific peoples and some ethnic communities.

65. In addition to views throughout the paper, the below table sets out how the current proposals impact specific population groups, based on agency feedback.

Population group	How the proposal may affect this group
Older people	Retaining public health measures aimed at limiting the spread of COVID (such as masking or self-isolation requirements) will benefit older New Zealanders. People aged 50 years and above have accounted for 626,048 cases (29% of total cases), of whom 2,440 have died (98% of total deaths) in the period to 29 January 2023.
Disabled people including tāngata whaikaha Māori	Whaikaha supports maintaining the status quo in relation to self-isolation. Engagement with disability community members has indicated that there is general support amongst the community to retain mandatory 7-day isolation in order to reduce the spread of COVID-19 within the community, provide protection for disabled people (particularly as voluntary mask wearing is low) and to give confidence to disabled people who want to participate in activities outside of their homes. In Whaikaha's view, it will be important to maintain isolation requirements in the context of the North Island flooding event – currently displaced people who are COVID-19 positive are transferred into isolation accommodation. It is important that disabled people displaced/impacted by the flooding event- or any other civil emergency - will not be unnecessarily exposed to COVID-19. Whaikaha considers that a reduction in mandatory measures would put at-risk populations at disproportionate risk. Recent Whaikaha analysis (not published) showed that Disability Support Service (DSS) clients were approximately 13 times more likely to die with or of COVID-19, than the rest of the NZ population (noting that not all disabled people are clients of DSS). Any decisions to step-down measures should be made on the basis of data and evidence regarding at-risk populations, such as disabled people, as well as through consultation with impacted communities. Whaikaha notes that New Zealand has obligations to disabled people as part of our commitments under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). The UN Committee examined New Zealand in 2022, and recommended that: "the State party closely consult and actively involve organisations of persons with disabilities in designing and implementing COVID-19 response and recovery measures, informed by the recommendations contained in the report 'Making disability rights real in a pandemic,' prepared by the Independent Monitoring Mechanism in 2021". Whaikaha notes that previous changes from mandates to guidance has been met with much less overall take-up (eg masking on public transport). Without a mandate in place, it is unlikely that people would continue to self-isolate. In addition, the removal of mandatory requirements to self-isolate may impact low-income workers, and the

	financial supports available to enable self-isolation (eg Leave Support Scheme). Whaikaha recommends that any changes to isolation measures would need to be communicated clearly, in accessible formats, in a timely manner. Disabled people have previously reported confusion when COVID-19 rules have changed and have advised that the communications provided were not always relevant or helpful for disabled people, particularly those who require additional information relating to disability needs. Whaikaha considers that face masks are a critical protective measure to help prevent the spread of COVID-19. Engagement with disabled people suggests general support for maintaining or scaling up face mask requirements. Any changes to further 'peel back' requirements to mask would not be received well by the community. Whaikaha also notes that disabled adults are less likely to report being in good health than non-disabled adults (62.6% and 90.8%, respectively - 2021/22: New Zealand Health Survey). A decision to remove masks in pharmacies and allied health may discourage disabled people from accessing the health supports they require. Whaikaha recommends that any decision to amend face mask policy settings would need to be supported by additional messaging reminding the general public that some disabled people and people with health conditions cannot wear a mask.
Māori	Te Arawhiti supports retention of case isolation requirements, noting that the pandemic continues to have a disproportionate impact on Māori and the need to protect vulnerable populations and reduce inequities remains key to New Zealand's stated ongoing precautionary approach to managing and responding to COVID-19. Due to a range of factors – existing health inequities, underlying risk factors, crowded living arrangements, working in jobs with greater risks of exposure – Māori have higher exposure to COVID-19 risk than other New Zealanders. Case isolation requirements remain our most effective measure to reducing transmission of COVID-19 and therefore reducing inequities. TPK notes that Aotearoa continues to be in a fragile economic state, vulnerable to a slowing world economy and the high dependence on imports. TPK considers that the impact of COVID-19 and the measures currently in place are not likely to contribute significantly to that situation, however recent flooding across the northern region could increase vulnerable populations' susceptibility to infection due to emergency accommodation and whānau providing shelter to neighbours and whānau. Te Arawhiti noted that the removal of case isolation requirements – though accompanied by strong encouragements for people to stay home if unwell and test – would result in the cessation of the Leave Support Scheme. The scheme is critical to supporting people to comfortably stay home when unwell, test and isolate – and therefore to reducing transmission. The impact of the cessation of the scheme would be heightened for Māori, due to existing social inequities that mean many Māori have lower levels of access to sick leave and are therefore at a greater risk of income loss if voluntarily isolating. Te Arawhiti also has concerns in relation to the message that the removal of case isolation requirements would send to the general

	population – that isolating is no longer a necessary behaviour to support the reduction of COVID-19 transmission. In the context of the international subvariant context, and flood events in the northern region, TPK recommends that a status quo approach be taken over the next few weeks. Strong encouragement to stay home may not be sufficient if whānau do not have access to supports to stay home, and this may result in more people who are infectious circulating in the community. Removal of the requirement to self-isolate could have negative impacts on Māori Business - small Māori businesses and sole traders (which make up a large proportion of the Māori business landscape) are particularly impacted by an increase in community cases, which would be likely occur if the requirement to isolate was removed. TPK notes the need for increased testing and vigilance in those disrupted communities and where necessary to provide accommodation to those with COVID to mitigate the risks. This would help manage the impact of increased gastro infections likely from the flood events, and the potential for greater harm from co-morbidities where these infections combine with COVID-19. Te Arawhiti and TPK support the retention of status quo mask requirements.
Pacific peoples	The COVID-19 pandemic has exacerbated existing inequities for Pacific peoples, who have had the highest hospitalisation rates for COVID-19 and experienced mortality rates four times greater than European and other population groups. MPP advised that while cases have been decreasing over the past month, the potential for XBB.1.5 to lead to a further wave of infections should also be factored in. Given this, MPP recommends that the status quo should be retained for case isolation and mask requirements. MPP notes that this would reduce the impacts on a further wave on Pacific peoples, who are one of the most economically vulnerable groups in New Zealand.
Ethnic communities	MEC notes reports from some small ethnic business owners that they remain concerned about staffing shortages due to staff being unwell, isolating, and unable to work. This is particularly a concern within the hospitality industry. In addition, MEC has received feedback that access to the COVID-19 leave support scheme has varied in some communities. For economically vulnerable ethnic communities, this is a concern and may be a driver for individuals to not report positive cases or return to work sooner (even if they are unwell). MEC notes that if the status quo option was preferred, in order for it to fully deliver on its objective of minimising risks of community transmission, then some consideration would need to be given to ensuring that employers continue to apply for the COVID-19 leave support scheme for their employees, and that people isolating continue to have access to Care in the Community support networks and services. MEC also notes that the continuation of the status quo may give reassurance to some ethnic communities who are more vulnerable to COVID-19, such as the elderly and those with an underlying health condition(s). MEC notes that the accommodation and food services industry is one of the top industries that ethnic communities work in. For people who

	work in industries where they are unable to work from home, the removal of mandatory isolation could enable them to return to work sooner(if they are feeling better or return a negative test earlier), potentially safeguarding their economic security. If self-isolation were to become voluntary, MEC recommends that consistent, clear, and simple communications should be provided to ethnic business employers and employees to improve compliance and to ensure that key messages of "strongly encouraging" self-isolation are received, and employees do not feel pressured to return to work sooner because isolation is no longer "mandatory". This should be accompanied by clear and accessible messaging on the risks and implications of long COVID on people's health, particularly as trying to go back to work too early can cause an exacerbation in symptoms. Greater clarity on eligibility for the COVID-19 leave support scheme for employees who choose to self-isolate could improve compliance. MEC notes that some vulnerable ethnic communities may turn to self-isolation to protect themselves if self-isolation became non-mandatory, which may lead to increased anxiety and loneliness, particularly for vulnerable elderly people. MEC notes that the continuation of the status quo in relation to mask requirements may give reassurance to some ethnic communities who are more vulnerable to COVID-19 such as the elderly and those with an underlying health condition(s).
Other groups	*Corrections / Paiheretia* The prison population has a high rate of co-morbidities and a high proportion of Māori and Pacific people in custody, coupled with close living quarters and at some sites, poor ventilation, as well as significant numbers of staff and contractors entering the prison for work each day from the community. Together these factors make the prison environment a high-risk setting. Continuing the current self-isolation requirements supports Corrections to keep prison environments safer. Any removal of the 7-day isolation requirement requires Corrections, and others managing closed environments, to consider how to manage the risk of staff returning to work who may still be infected. Public health guidance is needed to support such agencies to understand how to implement workplace safety protocols that protect vulnerable people who do not have a choice about who they come into contact within closed environments. OT note that youth in Youth Justice Residences are in a similar position as the prison population in terms of risk. Youth Justice Residences are currently full to overflowing, so would potentially be a very vulnerable community. *People with Long COVID* The Director-General notes that reductions in public health measures will increase prevalence of Long COVID for vulnerable population groups, and pose a risk to those who already have Long COVID as they are more susceptible to reinfection. *Children and young people* OT note that they support the proposed approach to retain current mandatory measures as a justified and sensible approach.

	OT has also commented that children under 5 are unable to access COVID-19 vaccines at this time, and while older children may be able to, their access will be dependent on decisions made by their parents or guardians. The public health measures recommended to remain in place will add a level of protection to children who may be more vulnerable because they are unvaccinated. In addition, maintaining mandatory use of masks in health services and mandatory isolation periods will provide clarity to the caregivers of children in care. This can be helpful and reduce tension when views about health measures differ between caregivers and a child's parent/s or guardian/s. The mandatory isolation of cases for 7days will provide parents with clarity around their responsibilities to remove children from school when they have COVID-19, helping to reduce the spread of COVID-19 in school settings. This is likely to increase children's access to education overall. OT has also noted that children are often not in a position to remove themselves from the presence of adults, such as teachers or sports coaches, who are sick. Maintaining the mandatory isolation of cases for 7days will reduce children's exposure to adults who have COVID-19. *People affected by recent weather events in the northern part of the North Island* Potential impacts noted for this group include: • people who have been displaced from their usual place of residence may find it difficult to isolate; • people may be under increased financial hardship; • there may be an increased risk of community transmission, particularly in settings where large groups of displaced people are living temporarily[1] or in private houses that have become overcrowded due to taking in displaced whanau or family. *Tertiary education sector* MoE advises that their view is that in general, schools and tertiary education settings will reflect the community incidence of cases and the Ministry's view is that we should continue to be health-led on the need to isolate. MoE advises that tertiary providers are conscious of their obligations to learners and staff (eg. under Health and Safety at Work Act 2015, WorkSafe regulations, Education and Training Act 2020, Human Rights Act 1993, Privacy Act 2020, and the tertiary and international Code of Practice). There may be concerns from Tertiary providers about risks of increased transmission amongst staff and students. From feedback in the past, these concerns will be significant amongst vulnerable or immune-compromised staff and students, including people with disabilities, and older staff and students. There may also be concerns about impact for Māori and Pacific students and staff and their whānau and families.

[1] As of 3 February 2023, NEMA advises that there were 5 Civil Defence Centres (CDCs) providing temporary shelter for around 90 displaced people. CDCs are temporary, and will pop up or wind down depending on the needs throughout the response. In addition, NEMA advises that 7 marae were providing active shelter for displaced people.

	MoE advises that tertiary providers have provided feedback that they prefer not have to impose their own restrictions if there were no Government requirements in place – and also that they would rather have a clear government mandated restriction for longer, than to have frequent changes or have to impose their own restrictions. *Aviation sector* The Ministry of Transport (MoT) has provided feedback that case isolation requirements are impacting on existing workforce shortages across the aviation sector which are already under significant pressure. The recent weather events in Auckland has resulted in additional significant disruptions to the aviation system. MoT reports that the aviation sector would support a reduction in the period of mandatory isolation to 5days, to enable staff who are recovered to return to work if they are well. The sector's estimate in December 2022 was that for airlines alone this could bring over 80 critical operational staff a day back to work. The sector is also mindful of pressures on the system from already planned events that will create peaks in demand, for example of the FIFA Women's World Cup which is taking place in the coming months. *Housing provider sector in northern regions* HUD has noted that there is a potential impact to Housing Providers in Northern Regions should there be a resurgence in cases due to recent flood events, which have put some pressure on providers and accommodation.

Memo

COVID-19 Public Health Risk Assessment – 26 January 2023

Date:	31 January 2023
To:	Dr Diana Sarfati, Director-General of Health, Te Tumu Whakarae mō te Hauora
Copy to:	Dr Andrew Old, Deputy Director-General, Public Health Agency, Te Pou Hauora Tūmatanui, Manatū Hauora Ministry of Health
From:	Dr Nicholas Jones, Director of Public Health, Public Health Agency Te Pou Hauora Tūmatanui Manatū Hauora Ministry of Health
For your:	Information and Decision

Purpose of report

1. This memo provides advice from the Director of Public Health following the 26 January 2023 COVID-19 Public Health Risk Assessment (PHRA). That PHRA considered whether any changes are required to existing COVID-19 settings, including mandatory requirements and other matters based on the current outbreak context and modelling.

Summary of Recommendations

2. The purpose of the COVID-19 PHRA is to assess the current and medium-term COVID-19 risk and to consider whether there needs to be any changes to the suite of public health measures to manage the risk. This can include recommendations to relax or escalate risk mitigation measures. In addition, the PHRA fulfils the legal requirement to keep mandatory measures (made via Orders) under regular review to ensure that they remain necessary and proportionate.

3. When combined, individual measures form a pragmatic approach to managing COVID-19. There are interdependencies between each, and we must remain aware of how they form a coherent package for the public to encourage and support public health behaviours necessary to reduce transmission and limit the impact of COVID-19.

4. The principle of proportionality is a key consideration. This principle requires that the least restrictive measures are used and for no longer than is necessary to achieve the objective of preventing, minimising, or managing the COVID-19 public health risk. In assessing proportionality, it is important to account for both Tiriti o Waitangi and equity considerations as more restrictive measures may be required to achieve these objectives.

5. The focus of the PHRA Committee meeting on 26 January was to assess the current public health risk arising from COVID-19 in Aotearoa New Zealand based on data and recent model outputs. The Committee did discuss all current mandates but rather than considering specific options for change identified specific issues requiring further analysis

prior to the next risk assessment. Based on the PHRA Committee's deliberations, the Director of the Office of Public Health recommends the following:

1. Point of Care Testing Order

Current requirement	Regulation of Rapid Antigen Tests under the Point-Of-Care Tests Order.
Director of Public Health recommendation	**Retain** current Point of Care Testing Requirements pending further review by Outbreak Response on the implications of revoking the order

2. Face masks

Current requirement	The COVID-19 Public Health Response (Masks) Order 2022 specifies that: 1. face masks are mandatory for visitors in health service settings including primary and urgent care, pharmacies, hospitals, aged residential care (ARC), disability-related residential care, allied health, and other health service settings) 2. there are exclusions for: patients and people receiving residential care, health service staff, and visitors to specific health services (psychotherapy, counselling, mental health and addiction services).
Director of Public Health recommendation	1. **Retain** the current face mask mandate in health service settings, while further work is undertaken before the next PHRA to consider whether the range of health service settings captured by the definition in the Order remains appropriate (with a specific focus on pharmacies and allied health settings). 2. Previous advice recommended re-instating a requirement for masks on public transport. Given the current stage of the outbreak, with lower cases and system impacts than pre-Christmas, this requirement is no longer recommended although general advice to wear masks in closed, crowded and poorly ventilated spaces still applies.

3. Case isolation

Current requirement	Mandatory 7-day self-isolation of COVID-19 cases.
Director of Public Health recommendation	**Retain** the 7-day case isolation requirement. Conduct review of isolation requirements prior to the next PHRA in the light of recent changes to World Health Organisation recommendations.

Background and context

High-level summary of the outbreak status and epi-context

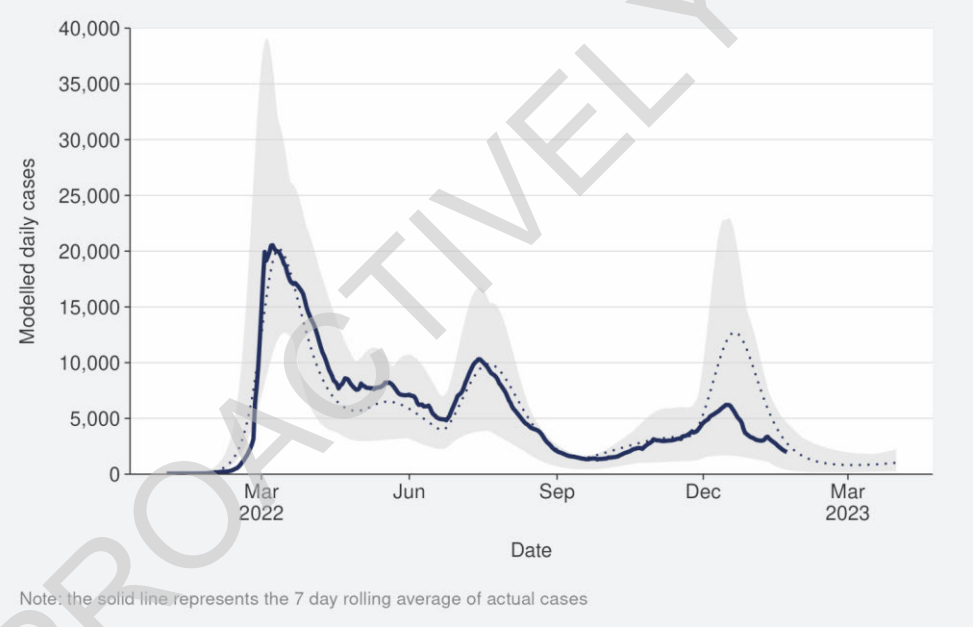
COVID-19 cases and hospitalisations are trending downwards

6. Overall, the key measures of infection (levels of viral RNA in wastewater and reported case rates) used to monitor the COVID-19 epidemic continue to decrease in most regions after peaking in mid-December 2022.

7. COVID-19 related hospital admission rates have also decreased since the start of 2023, while mortality counts are tracking well below the expected modelling. Hospitalisations that are classified as being 'for COVID-19' are higher than the incidental rate. Between 1 January and 16 January 63% of COVID-19 related hospital admissions were patients coming in for COVID-19 related illness rather than incidentally having COVID-19.

8. The lower-than-expected reported cases, hospitalisation and mortality rates may be, in part, due to a change in the public's behavioural patterns over the summer period. Cases may return to following the modelled range as people return to their usual habits and schools reopen. The committee noted that previous behavioural surveys have suggested a high proportion of positive cases report positive RAT results, but it is possible that reporting and testing behaviour also changed over the holidays. There was a large increase in reporting of positive RAT results in the 15 to 24 year age group in the second week of January. The increase could have resulted from social events over the New Year holiday, changes in testing and reporting or both factors. Further data on testing and reporting will be collected over the next few weeks.

Figure 1 - COVID-19 Modelling Aotearoa scenarios compared with national through 22 January 2023[1]



Vulnerable populations have the highest rates of hospitalisation

9. Despite decreasing cases of COVID-19 infections and hospitalisations there are still differences in the age standardised hospitalisation rates by ethnic group. Recent hospitalisation data show Pacific peoples were at considerably higher risk of hospitalisation over December. In the week ending 16 January Māori had the highest age adjusted admission rate (1.7 per 100,000).

10. Further, a review of people with disabilities experience of COVID-19 [HR2022017250 refers] found that Disability Support Services (DSS) recipients have had four times the risk of hospitalisation compared with the rest of the population during 1 January - 16 November 2022.

There is a lower uptake of the second booster

11. The first booster has seen a steady uptake with 71.5% of the eligible population having received their first booster. The second booster however has seen a lower rate of uptake with only 45.3% of the eligible population receiving this dose. This is specifically of note as the second booster is only available to higher risk populations.

There is currently no dominant variant in the community

12. There is a range of variants in the community with no one variant being dominant. The most common variant is CH.1.1, which is a sub-lineage of BA2.75, and now accounts for 34% of cases in the community. The next most prevalent are XBF at 19% of community cases, BA.2.75 at 17%, and BQ1.1 at 15%. BA.5 which was the dominant variant for most of 2022 has been steadily declining since November and now only accounts for 9% of the total cases.

13. XBB.1.5 (referred to as Kraken in the media) has not currently taken hold in New Zealand as it has in the United States (US). In the US we have seen XBB.1.5 demonstrate a growth advantage over other new variants and it is possible that this could become the new dominant strain of COVID-19 in New Zealand. It is notable that New Zealand has a different immune landscape to the US and so far, XBB (which XBB.1.5 is a subvariant) only accounts for 2% of total cases.

14. BF.7 is the leading variant emerging from China currently accounting for 33% of the total cases. This variant has been in New Zealand since October 2022 at low levels and does not appear to have a growth advantage over other variants.

Update on actions following PHRA of 2 January 2023

15. On 2 January 2023, a PHRA was carried out in response to growing case rates in China, and the emergence of XBB.1.5 in the United States. The purpose of the PHRA was to assess whether any change in settings was required in response to this international context.

16. The risk assessment determined that the risk posed by travellers from China entering New Zealand was minimal. Accordingly, the Committee advised against mandatory pre-departure or on-arrival testing of travellers from China. Instead, the Committee advised that operational changes were made to make information about testing more accessible to Chinese travellers, and that arriving travellers will be strongly encouraged to test voluntarily over a four-week period. This is a strictly time-bound programme of enhanced surveillance, which is not scalable or enduring.

17. Voluntary testing of a sample of passengers arriving on direct flights from China began on 20 January 2023. In the period 20 January to 26 January, 36% (353/970) of air border arrivals from China submitted a rapid antigen test (RAT). There were no reports of positive RATs.

18. In addition, officials from Manatū Hauora and Te Whatu Ora are continuing to work with ESR to further develop wastewater surveillance at airports, and potentially also from flights.

19. For the full context refer to the Manatū Hauora webpage, COVID-19 Trends and Insights which provides an interactive dashboard and regular analysis of the COVID-19 outbreak, including cases, hospital admissions and deaths.[1]

Risk Assessment

Cases are declining

20. The situation has improved since the last PHRA, with almost all indicators suggesting the public health risk posed by COVID-19 in Aotearoa New Zealand is low. Modelling undertaken in late 2022 suggests that this trend will continue, but the modelling does not factor in some context and influences, such as the possibility of new variants of concern, changes to vaccine eligibility or the use of antivirals.

21. As noted above, daily case numbers and hospital admissions are declining. Deaths have not climbed as high as was predicted pre-summer and have been relatively stable for the past few weeks.

Variants of concern

22. Omicron sub-variant XBB.1.5 continues to make up small proportion of cases since it was detected in Aotearoa New Zealand in mid-December 2022. While U.S. data suggests that it has a growth advantage over other sub-variants, the immunity profile of the New Zealand population is different to that of the U.S. population so it is unclear how this sub-variant will affect New Zealanders.

23. As noted above, China is reporting a large increase in Omicron sub-variant BF.7 cases as they transition from a ''Zero-COVID' policy toward less restrictive approach. But results from genomic testing in China has not detected any concerning mutations. Further, data suggests that BF.7 does not have a growth advantage in New Zealand.

[1] Note, the interactive dashboard has replaced the weekly Trends and Insights Report since January 2023. https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-trends-and-insights

Uptake of therapeutics

24. Uptake of COVID-19 therapeutics has been steadily increasing over recent months, and uptake is high among vulnerable populations. Just under half of Māori and Pacific Peoples aged 50-64 years who report positive tests are accessing antivirals. It is also important to note that uptake of therapeutics cannot be disaggregated by disability status, so it is uncertain what the uptake of therapeutics is among this group.

Seasonal factors have influenced trends

25. Cases tracked below expectations over the summer period. This is likely because of the behaviours and activity of people over this period. While there were high rates of domestic travel over the summer, activities taking place outdoors and away from education facilities and workplaces meant that transmission declined over this period.

26. This drop in case rates may also be partly due to the modelling not accounting for short-term changes in behaviour and because case ascertainment fluctuated over the summer. In particular with many people holidaying away from home, it is possible that people with symptoms were also less likely to test or report results.

Trends will be impacted by people returning to work and education

27. As people return to indoors locations through work, school and university, mixing rates will increase and case rates are expected to decrease at a slower rate or increase for a short time before continuing to decrease. The timing of the next COVID-19 wave is uncertain but may well coincide with the beginning of the winter respiratory illness season. Factors influencing the timing will include the population level of hybrid immunity to current variants and immune evasiveness of variants that emerge over the next months.

28. The committee noted that in the second half of 2022 the Northern hemisphere observed an earlier-than-usual flu season, placing unexpected pressure on healthcare services.[2] [3] This indicates some uncertainty around the timing of New Zealand's typical Winter flu season in 2023. If New Zealand observes a similar phenomenon, then the usual uptick in respiratory illnesses may begin as early as April 2023.

Director of Public Health Comment

29. In taking the above trends into account the Director of Public Health's assessment of current public health risk due to COVID-19 is that the risk is relatively low compared to other periods over the last 12 months and is likely to remain so for the next 6 to 8 weeks. There remains however an important difference in relative risk of hospitalisation for different ethnic groups when the age structure of different populations is taken into account.

Proportionality of retaining the status quo

30. The COVID-19 Public Health Response Act 2020 requires that the Government keeps Orders under regular review to ensure that any limitation they impose on rights or freedoms under the New Zealand Bill of Rights Act 1990 is justified and proportionate to the risk posed by COVID-19.

31. While daily case numbers and overall hospital admissions for COVID-19 are declining, and the overall uptake of antivirals is increasing, the risk posed by the virus to many groups within the population remains significant. Rates of COVID-19 mortality have been low and relatively stable for the past few weeks), the overall decline of case rates and hospitalisations may change as students and workers return to indoor areas, and uptake of

therapeutics among disabled people remains uncertain as it is not measured by current data collection.

32. The requirement to isolate as a case is a significant imposition on a person's right to freedom of movement. The intention is to reduce onward transmission. Recent WHO patient management guidelines have noted that risks of transmission from asymptomatic cases are considerably lower than from those with symptoms. The committee has requested that the Ministry of Health undertake further work to inform a decision on modifying the isolation order in line with WHO recommendations at the next assessment.

33. Enforcement of face mask requirements in non-hospital health settings such as pharmacies is challenging as it is not clear to pharmacy workers and customers who is considered a visitor who must wear a mask, and who is a patient (not required to wear a mask). The intended interpretation is that everyone who enters a pharmacy is required to wear a mask, but this requirement is rarely observed and is difficult to monitor and enforce.

34. Where the requirement is interpreted as intended, however, the mask requirement in pharmacies ensures that people who are at greater risk of severe illness from infection and who may be more likely to visit pharmacies, such as older or disabled people, are offered more protection when visiting pharmacies.

The basis for retaining current measures within this context

35. As the data indicates, reported case rates have tracked much lower than expected over the summer period, despite increased domestic travel. As noted, part of this is attributable to the changing interactions of the summer holiday period. While there is no robust data to determine the impact of the enhanced summer measures implemented in December 2022, they may have had a positive impact.

The changes implemented on 12 September 2022 have had an impact on transmission

36. Since the 26 January 2023 PHRA meeting, modelling has become available (and hence, it was not presented or discussed by Committee members) on how removing mandatory requirements and switching to guidance on measures relating to household contact isolation and mask wearing on 12 September 2022 may have impacted transmission. Modelling indicates that transmission increased by approximately 20% from mid-September to early November, likely due in part to the changes in behaviour resulting from the removal of mandatory measures. The expected increase in transmission prior to this switch to guidance was 8.5%, based on international evidence about levels of compliance under guidance.

37. Modelling on current mandatory case isolation indicates that:

- if the current measures are retained, the daily hospital occupancy will reach between 250 to 300 beds occupied daily over the next two months
- a change to case isolation requirements that results in an increase in transmission of 7.5%, will cause an approximate 50% increase in peak bed occupancy in hospitals in the two months following the change (requiring around 125-150 extra beds to be occupied compared to status quo settings)
- a change in case isolation requirements that results in transmission increasing by 10% will cause an approximate 70% increase in peak bed occupancy in

hospitals over the two months following the change (requiring around 150 - 175 extra beds to be occupied compared to status quo settings).

38. See Appendix 2 for assumptions and caveats of the modelling, and for graphs representing the scenarios outlined in paragraphs 30-37.

39. These predicted outcomes based on transmission increasing by 7.5% and 10% (in addition to the transmission change following September 2022 policy changes) as a result of any change to case isolation requirements, should be understood in light of the modelling that shows the removal of household contact isolation and mask wearing requirements in September 2022 resulted in a 20% increase in transmission.

Case isolation is still considered to be an effective measure

40. The rationale for continuing to require self-isolation is as follows:

    a. Isolation of cases remains the cornerstone of New Zealand's public health response to COVID-19. This measure significantly limits transmission of COVID-19 as it helps to break the chain of transmission by reducing the proportion of infectious people having contact with and infecting others in the community, many of whom may be at high risk of poor outcomes.

    b. Without mandated case isolation, it is highly likely adherence to guidance would be lower, resulting in more infectious cases seeding community transmission and increasing overall case rates.

    c. Overseas evidence suggests that a legal requirement to isolate results in significantly greater adherence than a recommendation to isolate. Experience when other mandates (eg masks) have been removed in New Zealand reinforces the fact that adherence to guidance is typically much lower than to mandates. However, given cases may be unwell from the symptoms of COVID-19, there may be a higher adherence to self-isolation guidance than for other measures.

    d. Other infection control tools, such as requiring face masks or physical distancing are significantly less effective than isolation. We have been able to recommend removing or reducing some of those other tools in part because case isolation has remained in place. However, there is no combination of other mechanisms that would come close to producing the broad public health benefits provided by mandatory case self-isolation, including the minimisation of disruption to essential services caused by high transmission of COVID-19.

41. Advice from the 7 November 2022 PHRA continues to be relevant and has been added to Appendix 1 to ensure that this measure continues to be reviewed and monitored. This ensures that it remains a proportionate and effective at limiting the impact of COVID-19. Appendix 1 outlines the efficacy of mandated case isolation in comparison to voluntary (but encouraged) case isolation, emphasises the role that case isolation plays in an equitable health response to COVID-19 and notes that 7-day isolation is an appropriate duration for cases to isolate.

42. Further work is being undertaken before the next PHRA to consider whether case isolation requirements should be modified, in light of recent World Health Organisation (WHO) changes to recommendations[4] relating to isolation (particularly in relation to people who are asymptomatic).

Face masks are also still considered to be an effective measure

43. Evidence that wearing a face mask decreases the rate of COVID-19 community transmission (and other airborne respiratory viruses) is substantial (HR20221311 outlined the evidence base of their use and mandates). Overseas evidence suggests mandates increase adherence[5,] are associated with reductions in COVID-19 case and mortality growth rates[6 7 8 9,] and the that the timing of when face mask mandates are applied matters - early application is associated with a reduction in cases and mortality rates.[10]

44. Face mask mandates lean against inequity, to ensure that people who are at higher risk can access basic services without avoidable additional risk. A conservative estimate is that one in every six New Zealanders is at higher risk of severe illness if they contract COVID-19.[11] Mandates have two benefits for this group of people: it means that they will be less likely to be infected, and be more likely to feel able to continue to safely participate in basic activities of life (for example accessing healthcare, visiting a pharmacy).

Despite some issues, face masks are particularly important in health service settings

45. Health service settings have a series of characteristics that elevate the risk of transmission and/or the risk of severe disease. These settings and the services provided within these settings typically:

    a. may be more likely than other settings to have people present with undifferentiated viral illness, either because they are seeking help for symptoms or because they have a co-existing medical emergency

    b. are more likely to have vulnerable people present, either due to disability, advanced age, underlying conditions, or to being unwell at the time - facility-level face mask requirements lean against inequity, to ensure that people who are at higher risk can access health services without avoidable additional risk

    c. have variable capacity to reduce crowding, indoor ventilation and/or air filtration[12]

46. People with hospital-acquired COVID-19 infections are more likely to have poorer outcomes than community-acquired infections[13]. Feedback from two districts in late 2022 noted possible links between visitors and hospital-acquired cases of COVID-19. The need to access healthcare means people often do not have a choice in whether they access a health service.

47. While adherence to face mask requirements may be waning or patchy in some health service settings, adherence could drop further if the mandate was removed, as evidenced by the decreased use on public transport since the mandate was dropped in mid-September (but has remained recommended by Manatū Hauora).

48. Further work to be undertaken before the next PHRA includes a consideration of whether the range of health service settings captured by the definition in the Order remains appropriate (with a specific focus on pharmacies and allied health settings).

Equity and Te Tiriti o Waitangi considerations for maintaining the status quo

Impact of COVID-19 on vulnerable populations

49. Pacific peoples and Māori continue to have the highest hospitalisation rate compared to other ethnicities, after standardising by age. Māori are 1.8 times more likely to be admitted to hospital with COVID-19 than European or Other, and Pacific Peoples are 2.3

times more likely. Age standardised rates of Pacific Peoples being admitted to hospital with COVID-19 increased substantially over the summer period.

50. COVID-19 attributed mortality rates are also higher among Pasifika (2.1x higher) and Māori (1.7x higher), compared to European or Other ethnicities.

51. The most deprived populations continue to have the highest rates of hospitalisation (1.1 per 100,000), compared with those who are least deprived (0.8 per 100,000). There is also an increased risk of COVID-19 attributed mortality for those in socio-economically deprived groups. The most deprived 20% of the population have 3 times the risk of mortality when compared with those in the least deprived 20%.

52. Disabled people aged <65 years who receive Disability Support Services have a hospitalisation risk that is 4 times higher than the rest of the population. Further, rates of COVID-19 attributed mortality are 15 times higher among this group compared to the rest of the population.

53. Despite the lack of information on whether any changes would increase the disproportionate impact on these populations, Committee members emphasised that any reductions of public health measures will increase prevalence of Long COVID, and that this increased prevalence will disproportionately impact Māori, Pacific Peoples and disabled people due to their vulnerability to infection. This is particularly concerning given that the criteria for diagnosing Long COVID and Long COVID support systems remain under development and given that these groups are more often under-diagnosed and under-treated when accessing healthcare.[14] [15] [16] [17] [18] [19]

Addressing equity concerns

54. There is an ongoing and strong concern among Committee members that a reduction in measures would put vulnerable populations at disproportionate risk. They emphasise that decisions to step down measures should not be made based on population-wide data and context, but rather on the data representing specific vulnerable groups such as disabled people, Māori and Pacific people, and older people.

55. In a Manatū Hauora survey conducted between 29 September and 9 October 2022, Māori health providers indicated that targeted Māori holistic immunisation programs and addressing the impacts of Long COVID were the areas of highest importance for them and their communities.

56. The new COVID-19 response strategy sent to the Minister on 27 January [H2022018568] has noted that COVID-19 vaccination efforts and Māori COVID-19 communications have highlighted the importance of Māori leadership at all levels; putting equity at the centre of decision making; enabling providers to build relationships with communities; enabling communities to lead responses, and collaboration across agencies. It also notes the disproportionate risk that Māori face of getting Long COVID, and highlights how certain options would minimise this risk.

57. The increasing accessibility and uptake of antivirals for vulnerable populations is providing greater protection against the impact of infection. In the age bracket 50-64 years, antivirals have been provided to 55.89% of Māori cases and 41.96% of Pacific Peoples cases.

Equity considerations in these recommendations

58. It is important that public health measures improve health equity and uphold Te Tiriti o Waitangi principles by protecting groups who are most vulnerable to COVID-19.

59. There was broad support among Committee members for retaining each of the existing mandated measures to protect vulnerable communities. While Manatū Hauora did not have data to support it, Committee members from Te Aka Whai Ora, Whaikaha and the Māori Health Agency expressed that the removal of other measures in recent months have already put these communities at greater risk.

60. Shifting mandatory case isolation to guidance is likely to disproportionately affect those who do not have the ability to choose to follow the guidance. This includes people in precarious employment, those unable to work from home, workers with limited sick leave and other vulnerable populations, particularly those with other socioeconomic disadvantages.

61. Committee members emphasised that any stepping down or removal of protective measures should be accompanied by specific alternative settings, modelling against those alternative settings, and extensive engagement with stakeholders from vulnerable groups prior to stepping down measures.

62. Stakeholders from the disability community have expressed concern that there is insufficient data on the impact that removing protective measures would have on disabled people. They argue that decision makers should consciously factor in this absence of evidence before making decisions that could profoundly impact disabled people.

63. If the COVID-19 situation significantly changes, enforceable or mandatory measures may be re-introduced to protect our vulnerable populations. This would be an effective and proportionate response to a worsening risk profile.

New Zealand Bill of Rights Act 1990 (NZBORA) – s 9(2)(h) [redacted]

s 9(2)(h) [redacted]

64. s 9(2)(h) [redacted]

65. s 9(2)(h) [redacted]

66. s 9(2)(h) [redacted]

Next steps

67. Pending your agreement, we will share this memo with the Minister of Health's Office and the Parliamentary Counsel Office.

68. On 9 February 2023, you will provide advice to the Minister of Health that draws on this memo and any additional information or advice you wish to include.

69. That PHRA and your subsequent advice to Minister of Health will then inform a Manatū Hauora-led Cabinet paper on that topic to be considered by Cabinet's Social Wellbeing Committee on 14 February 2023, and then Cabinet on 20 February 2023.

Recommendations

It is recommended that you:

1.	Note	that key indicators currently suggest overall COVID-19 public health risk is low	Noted
2.	Note	that at-risk groups remain at disproportionately high risk	Noted
3.	Note	that key indicators and risk are expected to be impacted by the restart of school, university and people returning to their places of work from 30 January 2023.	Noted
4.	Agree	to recommend that the Minister of Health retains Point-Of-Care Test settings	Yes
5.	Agree	to recommend that the Minister of Health retains current face mask requirements	Yes
6.	Agree	to recommend that the Minister of Health retains current case isolation requirements	Yes
7.	Note	that the PHRA Committee is undertaking reviews of the measures (specifically mask and isolation requirements) ahead of the next PHRA	Noted

Signature Date: 31/01/2023

Dr Nicholas Jones
Director of Public Health
Public Health Agency | Te Pou Hauora Tūmatanui
Manatū Hauora | Ministry of Health

Signature Date: 1 February 2023

Dr Diana Sarfati
Director-General of Health | Te Tumu Whakarae mō te Hauora
Manatū Hauora | Ministry of Health

Appendix 1: Rationale for continuing to recommend mandating self-isolation for cases

Question 1: What is the rationale for an ongoing self-isolation requirement?

Purpose of self-isolation

3. A legal requirement to self-isolate remains the cornerstone of New Zealand's COVID-19 public health response. It significantly limits transmission of COVID-19 by breaking the chain of transmission by reducing the amount of infectious people having contact and infecting others within the community. In turn this limits hospitalisation, including the need for ICU care, and deaths, especially for more vulnerable populations. It also limits the number of people who will develop post-acute sequelae such as long COVID.

4. Without mandated case isolation and the associated support that it triggers, it is highly likely that adherence to guidance would be lower. This would lead to more infectious cases in the community, increasing overall case rates.

COVID-19 poses a substantial public health risk different from other respiratory and communicable diseases

5. COVID-19 can have a wide variety of impacts on individuals The majority of people infected will not need to go to hospital and will recover fully. However, a subset of people will have more significant health impacts – either in the acute or post-acute phrases of the infection.

    a. **Acute phase:** in reported cases to 22 January 2023, there have been 1,918,070 cases, of whom 25,673 (1.3%) were hospitalised, of whom 683 (2.7%) have required ICU care. There have been 3,754 deaths. Older people have substantially higher hospitalisation rates and, within each age group, Māori and Pacific communities, and people with disabilities have higher hospitalisation rates.[20]

    b. **Post-acute phase:** each new infection (or reinfection) effectively 'rolls the dice' for one or more post-acute sequelae. The rate and severity of post-acute sequelae, in combination with an expectation of multiple waves a year with the potential for reinfection make the impact more significant than other post-viral conditions. Post-acute sequelae include:

        i. Increased risk factors for a range of other health conditions: eg. cardiovascular disease[21], neurologic and psychiatric disorders[22], changes in brain structure[23], immune dysfunction[24], and diabetes.[25]

        ii. Long COVID[26]: based on evidence from overseas, 3-10% of cases are likely to develop long COVID, of whom 20% will have ongoing significant disability.[27] While these figures may appear low, in the context of two-to-three waves each year, each with the possibility of reinfection with each new variant or subvariant, over time the longer-term disability and productivity impacts will become as or more significant as the acute impacts on individuals and the health system.

        iii. Broader impacts: Long COVID and other post-acute sequelae have personal costs, costs to government (welfare and health), but also broader impacts on society[28], such as reduced workforce participation[29] [30] and productivity.

Vaccination and therapeutics reduce risk of severe disease, and less so, infection

6. Currently available vaccinations are protective against risk of severe disease (hospitalisation or death), and somewhat decrease the risk of infection and overall transmission in the community; less so for onwards transmission (ie transmission from an already infected person to another person).[31] But all levels of protection wane over time.

7. Antivirals also reduce the likelihood progression to severe disease, particularly for people at higher risk.[32] However, access to antivirals is currently limited, they must be taken within the first five days of symptoms, and they are contraindicated for people taking certain other medications.[33]

8. As outlined above, while to date we have been focused on the impacts during the acute phase (decreasing risk of severe harm), there is also health impacts in the post-acute phase. Most people who have post-acute sequelae will have had a mild acute case.

Immunity from reinfection wanes over time, and is largely variant-specific

9. Typically, a person will have some degree of protection from reinfection in the first month post-infection[34], however this protection is largely limited to reinfection with the same variant, and wanes over time. Reinfection is far more likely with a variant that is different to the one responsible for prior infections.

10. The planning assumption going forward is that New Zealand is likely to experience a minimum of two or more waves each year, until a sterilising vaccine can be developed.

Comparison to other infectious diseases

11. Best practice approach to managing infectious notifiable diseases transmitted through the droplet or airborne route is to require isolation of cases during their period of infectivity. This is the most effective tool for controlling disease transmission. The high transmissibility of COVID-19 reinforces the need for case isolation, which has been a cornerstone of the public health response throughout the pandemic.

Removing case isolation and associated support would increase health inequities

12. It is likely that the increase in community cases would affect some communities and population groups more than others. Specifically:

    a. There is an acknowledged differential exposure to COVID-19 risk related to socioeconomic status. People in lower socioeconomic groups are more likely to work in jobs with greater risk of exposure, to live in larger and typically more crowded houses, and to have underlying risk factors. If there are more infectious people circulating in a community with more baseline contacts, this increases the likelihood of onward transmission.

    b. People who are socioeconomically deprived are more likely to face challenges in being able to isolate compared to people with greater access to socioeconomic benefits. This includes differing access to sick leave, income loss, and potential pressure from employers to return to work. Earlier return to work comes at the cost of increasing transmission, which is likely a more significant effect on health outcomes and ability to work due to illness.

    c. As a result, people who experience higher levels of socioeconomic deprivation may be more likely to not test, not report results, or break isolation, potentially causing further cases and further inequities.

d. These inequities would likely be exacerbated, rather than mitigated, if requirements for self-isolation and associated supports (such as Care in the Community and the Leave Support Scheme) – which are vital for enabling people in in these communities to practically be able to isolate were removed.

Recent feedback from sector stakeholders echoed many of the concerns above

13. *Compromising equity aims* – the Leave Support Scheme (LSS) is closely tied to isolation mandates. Loss of the LSS would present risks for vulnerable populations and workforces with fewer protections.

14. Coercion to return to work particularly for the most vulnerable – strong concern was expressed that if the isolation mandate was removed, employees may be pressured to return to work even if not fully recovered. Equity concerns were central to this feedback, particularly what this change might mean for Māori and Pacific communities.

15. Increased transmission because of relaxed requirements – removing the isolation mandate will almost certainly result in increased transmission, due in part to the message it sends regarding the importance of isolation and because of the inability of people to isolate due to the two factors above. Again, equity concerns were raised as any increase in cases will impact the priority populations most.

Impact the self-isolation requirement is having on reducing the number of cases in the community

16. Based on available information, the requirement for self-isolation is having a strongly positive impact on reducing community transmission.

17. Rapid antigen tests (RATs) are currently New Zealand's primary testing tool for people with COVID-19 symptoms or household contacts. RATs are very effective at identifying people who are infectious, which is the most critical factor for isolation.[35] Under the current evaluation framework, all point-of-care tests permitted in New Zealand must have a minimum of 80% sensitivity and greater than 98% specificity (or a minimum of 90% sensitivity for Ct values less than 25).

    a. Surveys have shown that people remain aware of the importance of isolating, and are willing to do so.

    b. In July 2022, 88% of people surveyed indicated they were willing to isolate if they had COVID-19, were symptomatic, or if a household member tested positive.[36]

    c. In an online survey of 1,505 adults undertaken 15-20 September 2022, preliminary data received on 11 October 2022 shows 8% of participants had tested positive for COVID-19 in the past two weeks and 9% of participants were self-isolating in the same two-week period.

It is very clear that compliance will be significantly higher with a mandate than not

18. Evidence from overseas suggests that a legal requirement to isolate will have significantly greater adherence than a recommendation to isolate. For example, in the United Kingdom, there was a significant drop in after the legal requirement was dropped on 24 February 2022. Survey data of people who tested positive for COVID-19 showed 80% were fully compliant in February but dropped to 64% in early March and then 53% in late March 2022.[37]

19. Experience when other mandates have been dropped in New Zealand reinforces the fact that adherence to guidance is typically much lower than to mandates:

    a. Face masks on public transport – there was a noticeable decrease in the proportion of people masking when it shifted from a requirement to a recommendation.

    b. Face masks in schools – similarly, when masks were dropped as legal requirement in schools, (but remained as a recommendation) many Boards of Trustees opted not to require ongoing making.

20. Data insights produced 27 January 2023 show that changes in behaviour caused transmission to increase by 20%, likely as a direct result of the removal of certain mandatory mask-wearing requirements and the removal of household contact isolation requirements, in favour of guidance, on 12 September 2022.

Self-isolation requirements remain the most effective tool

21. While there has been a reduction of isolation requirements over the course of the outbreak, we have reached what is probably the minimum threshold for self-isolation to remain an effective intervention.

22. As described above, the experience when other jurisdictions have shifted from mandated isolation to guidance for isolation, adherence has dropped significantly. Similarly, when mask mandates for schools and public transport were shifted to guidance, again, there was a significant, and sustained drop in use of these public health protections.

23. Other control tools, (eg. face masks or physical distancing) are significantly less effective than isolation. Also, we note that to be effective these tools are most effective when utilised across the entire population. We note it is important to see these tools as a suite of protections that work together. Each tool can be dialled up or down. We have been able to recommend removing or reducing some of those other tools in part because isolation has remained in place. However, there is no combination of other mechanisms that would replicate the public health benefit required self-isolation provides.

Question 2: What is the appropriate length of time for self-isolation?

24. Modelling undertaken by CMA in September suggested that the current mandatory isolation policy is approximately preventing 450 hospitalisations and 50 deaths in the short term compared to guidance with a reduction to 5 days. Over a year, it is estimated to prevent 1000 hospitalisations and 300 deaths. This modelling was conducted prior to the emergence of the variants of concern mentioned in the outbreak status section, so should be interpreted as a minimum estimate.

25. When current settings are compared to mandatory with test to release from 5 days, the model estimates current settings are preventing 40 hospitalisations and 50 deaths in the short term. Over a year, it is estimated to prevent 250 hospitalisations and 30 deaths.

26. Accurate domestic data on the behavioural impact of shifting from mandatory isolation to guidance is lacking. However, data from the UK infection survey (based on adherence rates to guidance in the UK) suggests potentially larger increases in cases and hospitalisations from such a change.

27. Key limitations of the isolation model are that it assumes RAT sensitivity to be constant over the duration of illness and does not account for increased sensitivity at day 5. This means that the proportion of cases released who are infectious may be overestimated. Another limitation is that incomplete isolation under mandatory requirements is not fully accounted for. Both limitations would tend to overestimate the magnitude of increase associated with changes to the status quo. Furthermore, the modelling does not account for a new variant which could substantially increase infections.

28. In the PHRA of 22 November 2022, 5-day self-isolation plus test to release was also reviewed as an option to, in some cases, reduce the length of time people would isolate. Key concerns noted with this proposal at that time remain relevant:

    a. Most people would still be infectious upon release, leading to further seeding of cases in the community.

    b. A partial change creates uncertainty to the public on when to isolate and many might view the isolation period as just 5 days.

    c. People, especially in lower income areas, may be pressured to return to work after 5 days and not 7. Even when testing negative many people are still symptomatic on day 5. Further, going back to work early can result in a longer recovery period.

    d. While the relaxing of settings will reduce the time spent in isolation it will increase the number of infectious people in the community. With cases currently rising it is not an appropriate time to relax measures. Operationally this will put further stress on the health care system.

    e. Any increase in COVID-19 infections will have a disproportionate effect on the most vulnerable communities.

    f. There is not equitable access to RATs. A test to release programme requirement will only benefit those who can easily access RATs

29. It was noted that further change, such as the introduction 5-day self-isolation plus test to release, is likely to create additional uncertainty and confusion.

30. People are more likely to adhere if isolation is mandatory. However, we have no accurate estimate of the proportion of people following the mandatory required. Behavioural data indicate 88% of those surveyed (July 2022) would follow isolation rules if they tested positive. Operational providers have reported that they believe the most critical factor is not whether isolation is mandatory or recommended, but rather whether people are adequately supported to do so.

31. Detailed modelling results were provided in the PHRA of 3 October 2022.

Appendix 2: Assumptions and Caveats of modelling, and supporting graphs

Assumptions and caveats

32. Inference of level of change in case and contact isolation behaviour is only suitable for a relatively short time period following the policy changes, and these are based on best

guesses from previous observation. We have little information on observed behavioural changes through direct examination.

33. There are a number of complex factors that influence the reproduction number Rt, including introduction of new variants with different levels of infectivity, changing travel patterns, increasing numbers of large community events, and reduced case ascertainment and contact tracing. These are not captured in current modelling.

34. **Case isolation assumptions**: With mandated 7-day isolation, it is assumed that 90% of transmission for identified cases is prevented.

35. **Long-term trajectory assumptions**: The model assumes BA.5 and the previous mix of variants is the prevalent variant landscape for the next 12 months and no changes to vaccination eligibility (e.g. third boosters, second boosters for more groups) and no change in available therapeutics.

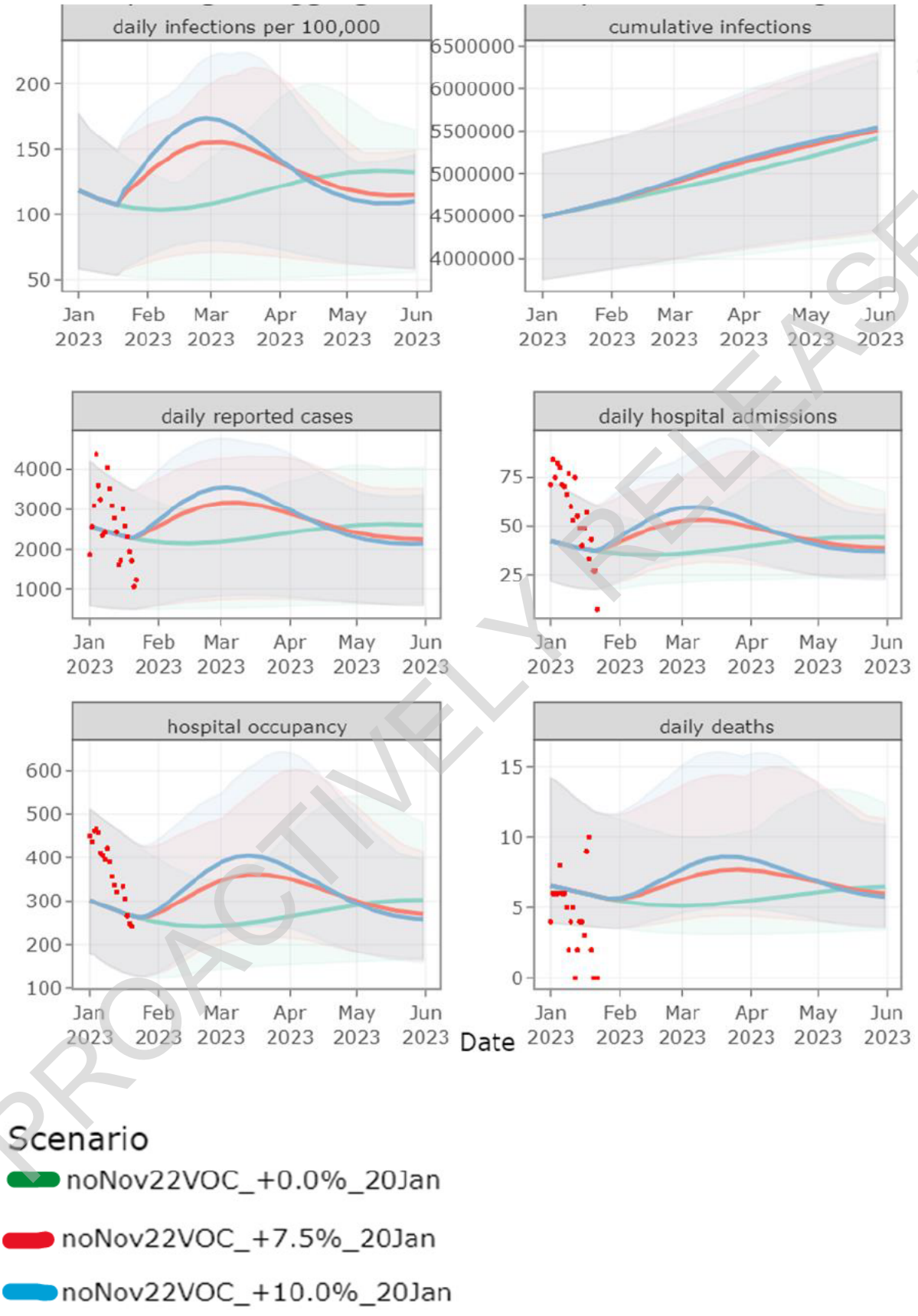
36. **The model assumes no new variants occurring in the future:** Beyond November, simulations do not account for new variants of concern or their potential impact on cases, hospitalisations and deaths.

37. **Peaks and troughs assumptions:** Because this is a single national model, it may not capture the different size, shape and timing of peaks at a district or regional level. Therefore, the model may overestimate peaks and underestimate troughs, if outbreaks in different population groups are not aligned.

38. **Uncertainty around modelled estimates:** The provides credible intervals around estimates of cases, hospitalisations and deaths. This range reflects unknowns such as the share of infections detected and the speed of waning immunity. The model is fit to data up to 15 November 2022, which reduces some of this uncertainty.

39. **Uncertainty around "guidance" vs "requirements"**: It is difficult to say what model parameters to use to model the difference between mandates and guidance. Compliance and behaviours under a 'guidance' scenario will depend not only on what level people are inclined to follow guidance but also the level of communication around guidance. The model assumes the effect of guidance was an 8.5% increase in transmission, but observation of case data indicated it was a 20% increase. While modellers do not know what will happen in the future, they have empirical evidence that shows that switching to guidance had a much bigger impact than anticipated in the past, and we can quantify that it was approximately 2 times higher than initial assumptions.

Comparison of all aggregated metrics by scenario through time



Endnotes

[1] COVID-19 Modelling Aotearoa, ordinary differential equation model, December 2022
[2] https://www.who.int/europe/news/item/01-12-2022-joint-statement---influenza-season-epidemic-kicks-off-early-in-europe-as-concerns-over-rsv-rise-and-covid-19-is-still-a-threat
[3] https://www.cdc.gov/flu/spotlights/2022-2023/early-flu-activity.htm
[4] https://www.who.int/news/item/13-01-2023-who-updates-covid-19-guidelines-on-masks--treatments-and-patient-care
[5] Adjodah D, Dinakar K, Chinazzi M, Fraiberger SP, Pentland A, Bates S, et al. (2021) Association between COVID-19 outcomes and mask mandates, adherence, and attitudes. PLoS ONE 16(6): e0252315. https://doi.org/10.1371/journal.pone.0252315
[6] Guy GP Jr., Lee FC, Sunshine G, et al. Association of State-Issued Mask Mandates and Allowing On-Premises Restaurant Dining with County-Level COVID-19 Case and Death Growth Rates — United States, March 1–December 31, 2020. MMWR Morb Mortal Wkly Rep 2021;70:350–354.
[7] Adjodah D, Dinakar K, Chinazzi M, Fraiberger SP, Pentland A, Bates S, et al. (2021) Association between COVID-19 outcomes and mask mandates, adherence, and attitudes. PLoS ONE 16(6): e0252315. https://doi.org/10.1371/journal.pone.0252315
[8] Mitze, T., Kosfeld, R., Rode, J., & Wälde, K. (2020). Face masks considerably reduce COVID-19 cases in Germany. *Proceedings of the National Academy of Sciences of the United States of America*, *117*(51), 32293–32301. https://doi.org/10.1073/pnas.2015954117
[9] oo, H., Miller, G. F., Sunshine, G., Gakh, M., Pike, J., Havers, F. P., Kim, L., Weber, R., Dugmeoglu, S., Watson, C., & Coronado, F. (2021). Decline in COVID-19 Hospitalization Growth Rates Associated with Statewide Mask Mandates, March-October 2020. *Morbidity and mortality weekly report*, *70*(6), 212–216.
[10] Wong, Angus K.; Balzer, Laura B.. State-Level Masking Mandates and COVID-19 Outcomes in the United States: A Demonstration of the Causal Roadmap. Epidemiology: March 2022 - Volume 33 - Issue 2 - p 228-236 doi: 10.1097/EDE.0000000000001453
[11] The Ministry of Health does not have precise figures for the number of New Zealanders who meet the definition of being at higher risk. However, in April 2022, the number of 'clinically vulnerable' people (which is defined more narrowly than 'high risk') was estimated at 800,000. 'Options for improving respiratory protection against aerosolised viral particles for vulnerable and priority populations' (HR20220682), 29 April 2022.
[12] Many health service settings do not have good design or engineering. Therefore, the value of face masks to protect those more vulnerable increases when there is frequent introduction of infection into those environments. This is true of community healthcare settings, but also is an issue in many hospitals as older wards are mostly multibed rooms (eg. 4-6), have shared bathrooms and no doors on rooms, making it hard to isolate and improve air filtration.
[13] In Victoria, Australia, 7.6% of hospital-acquired infections resulted in death, compared to 0.14% of reported cases in the general population in the same period. This shows that infections in hospital settings are associated with significantly (over 50-fold) higher mortality. Victoria Department of Health. 2022. Chief Health Officer Advice to Premier, 29 August 2022.
[14] Bhat, S, et al. 2022. *Ethnic Disparities in CT Aortography Use for Diagnosing Acute Aortic Syndrome.* Radiology: Cardiothoracic Imaging. Vol 4, No 6.
[15] Lee, C, Duck, I, Sibley, C. 2017. *Ethnic inequality in diagnosis with depression and anxiety disorders*. The New Zealand Medical Journal. Vol 130, No 1454.
[16] Atatoa-Carr, P, et al. 2008. *Rheumatic fever diagnosis, management, and secondary prevention: a New Zealand guideline.* The New Zealand Medical Journal. Vol 121, No 1271.
[17] Lennox, N, Kerr, M.P. 1997. *Primary health Care and people with an intellectual disability: the evidence base.* Journal of Intellectual Disability Research. 41(5). 365-372.
[18] Beange, H, Bauman A. 1990. *Caring for the developmentally disabled in the community.* Australian Family Physician, 19, 1558-1563.
[19] Wilson, D, Haire A. 1990. *Health Care Screening for people with mental handicap living in the community*. British Medical Journal, 301, 1379-1381.
[20] https://www.health.govt.nz/publication/covid-19-mortality-aotearoa-new-zealand-inequities-risk
[21] Xie, Y., Xu, E., Bowe, B. *et al.* Long-term cardiovascular outcomes of COVID-19. *Nat Med* 28, 583–590 (2022). https://doi.org/10.1038/s41591-022-01689-3
[22] Taquet M, Sillett R, Zhu L, et al. Neurological and psychiatric risk trajectories after SARS-CoV-2 infection: an analysis of 2-year retrospective cohort studies including 1 284 437 patients. Lancet Psychiatry 2022. doi:10.1016/S2215-0366(22)00260-7
[23] Douaud, G., Lee, S., Alfaro-Almagro, F. *et al.* SARS-CoV-2 is associated with changes in brain structure in UK Biobank. *Nature* 604, 697–707 (2022). https://doi.org/10.1038/s41 586-022-04569-5
[24] Phetsouphanh, C., Darley, D.R., Wilson, D.B. *et al.* Immunological dysfunction persists for 8 months following initial mild-to-moderate SARS-CoV-2 infection. *Nat Immunol* **23**, 210–216 (2022). https://doi.org/10.1038/s41590-021-01113-x
[25] Xie, Y. & Al-Aly, Z. *Lancet Diabetes Endocrinol.* https://doi.org/10.1016/S2213-8587(22)00044-4 (2022).
[26] Davis, H.E., McCorkell, L., Vogel, J.M. *et al.* Long COVID: major findings, mechanisms and recommendations. *Nat Rev Microbiol* (2023). https://doi.org/10.1038/s41579-022-00846-2
[27] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19latestinsights/infections
[28] Cutler DM. The Costs of Long COVID. *JAMA Health Forum.* 2022;3(5):e221809. doi:10.1001/jamahealthforum.2022.1809
[29] For example, a November 2022 report from the Office for National Statistics in the UK estimated that 2.1 million people living in private households (3.3% of the population) were experiencing self-reported long COVID (symptoms continuing for more than four weeks after the first suspected COVID-19 infection that were not explained by something else) as at 1 October 2022.
See https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19latestinsights/infections
[30] https://www.brookings.edu/research/new-data-shows-long-covid-is-keeping-as-many-as-4-million-people-out-of-work/
[31] Lin D-Y, Gu Y, Wheeler B, et al. Effectiveness of COVID-19 vaccines over a 9-month period in North Carolina. N Engl J Med. 2022. https://doi.org/10.1056/nejmoa2117128.
[32] Wen Wen, Chen Chen, Jiake Tang, Chunyi Wang, Mengyun Zhou, Yongran Cheng, Xiang Zhou, Qi Wu, Xingwei Zhang, Zhanhui Feng, Mingwei Wang & Qin Mao (2022) Efficacy and safety of three new oral antiviral treatment (molnupiravir, fluvoxamine and Paxlovid) for COVID-19 : a meta-analysis, Annals of Medicine, 54:1, 516-523, DOI: 10.1080/07853890.2022.2034936
[33] https://pharmac.govt.nz/news-and-resources/covid19/access-criteria-for-covid-19-medicines/covid-antivirals/
[34] https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-health-advice-public/about-covid-19/getting-reinfected-covid-19
[35] Routsias, J.G., Mavrouli, M., Tsoplou, P. *et al.* Diagnostic performance of rapid antigen tests (RATs) for SARS-CoV-2 and their efficacy in monitoring the infectiousness of COVID-19 patients. *Sci Rep* 11, 22863 (2021). https://doi.org/10.1038/s41598-021-02197-z
[36] The Research Agency (TRA). *July 2022 DPMC Behaviour & Sentiment Topline.*
[37] Phetsouphanh, C., Darley, D.R., Wilson, D.B. *et al.* Immunological dysfunction persists for 8 months following initial mild-to-moderate SARS-CoV-2 infection. *Nat Immunol* **23**, 210–216 (2022). https://doi.org/10.1038/s41590-021-01113-x
ttps://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandselfisolationaftertestingpositiveinengland/17to26march2022

Regulatory Impact Statement: Continuing with mandatory public health measures under the COVID-19 Public Health Response Act 2020

Coversheet

Purpose of Document	
Decision sought:	*Analysis produced for the purpose of informing:* a proposal to continue with the measures in place under the COVID-19 Public Health Response Act 2020
Advising agencies:	*Manatū Hauora – Ministry of Health*
Proposing Ministers:	*Minister of Health*
Date finalised:	9 February 2023

Problem Definition

Under the Bill of Rights Act 1990 (BORA) and the COVID-19 Public Health Response Act 2020 (the COVID-19 Act), the Government has a responsibility to ensure its response to the COVID-19 pandemic remains effective, justified, and proportionate.

Executive Summary

This Regulatory Impact Statement (RIS) sets out the information and analysis which informs the recommendation that there are no changes to the current settings under the legal framework for managing the COVID-19 pandemic. The framework is established under the COVID-19 Act. Specific requirements are set out in the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 (the Self-isolation Order) and the COVID-19 Public Health Response (Masks) Order 2022 (the Masks Order), both of which are made under the COVID-19 Act.

The Self-isolation Order establishes the requirement that COVID-19 cases (cases) self-isolate. This requirement is qualified by provisions which enable cases to leave their place of self-isolation to carry out high priority activities under highly restrictive conditions. These conditions include strict infection prevention and control measures.

The Masks Order establishes the requirement that people visiting healthcare services wear face masks.

The RIS draws on analysis including:

- information from the PHRA process
- detailed assessment of options against the criteria for the ongoing strategic approach to managing the COVID-19 outbreak
- Te Tiriti o Waitangi and Equity analyses.

The PHRA recommended that mandatory self-isolation for cases be retained. Isolation of cases remains the cornerstone of New Zealand's public health response to COVID-19. It significantly limits the transmission of COVID-19 by reducing the proportion of cases

infecting others in the community. Further we assessed that this measure is more effective than other less restrictive measures such as face masks or physical distancing, even in combination. Options to have a shorter isolation period, even with test to release, would significantly increase the public health risk.

Without government mandated isolation for cases, it is highly likely that adherence to guidance would be lower. This would result in an overall increase in transmission and case rates: increasing the risks of serious illness and hospitalisation for Māori, Pacific people, older people and people with disabilities (among other higher risk groups) and increasing pressures on the health system. Overseas evidence suggests that a legal requirement to isolate results in significantly greater adherence than a recommendation to isolate. Experience when other mandates (e.g., masks) have been removed in New Zealand suggests that adherence to guidance is typically much lower than to mandates.

The PHRA also recommended that the Masks Order be retained. Healthcare services cater to a range of vulnerable groups including sick, elderly, and disabled. It is also important that the public have confidence that health providers are low risk environments for COVID-19 transmission and are safe to access. For these reasons mask wearing in health care settings uniquely important.

Analysis summarised in this RIS supports the recommendations to maintain the current mandatory settings.

Equity and Te Tiriti o Waitangi analysis support retaining mandatory self-isolation for cases. Health outcomes from COVID-19 for vulnerable populations, including Māori, remain disproportionately high by comparison with the wider population. Shifting from mandatory to voluntary self-isolation would be highly likely to result in an increase in the number of cases, with the consequence of a disproportionate negative impact on health outcomes for vulnerable populations.

Implementation, monitoring, and review

The settings recommended are already in place and would require no additional implementation.

These measures remain under regular monitoring and review, including through regular Public Health Risk Assessments.

Limitations and Constraints on Analysis

This proposal is subject to a number of limitations:

- limited time to prepare this Regulatory Impact Statement
- data from modelling results are subject to significant uncertainty around the impact of policy changes, the level of immunity in the population and population behaviour
- limited time for detailed equity and Te Tiriti o Waitangi analysis, and due to timeframes and sensitivity, wider engagement has not been possible. Current measures, which are recommended to be retained, have been engaged on in previous PHRAs
- time constraints affecting the level of stakeholder engagement.

These limitations are acknowledged. However, the PHRA provides a robust process for consideration of proposed public health changes at pace. It draws on public health, policy, legal, operations and Māori health expertise, as well as detailed data and evidence. These

sources are supported by further stakeholder engagement and are set out in the Cabinet paper.

Responsible Manager(s) (completed by relevant manager)
Stephen Glover *Group Manager, COVID-19 Policy* *Strategy, Policy and Legislation* *Manatū Hauora*    *9 February 2023*

Quality Assurance (completed by QA panel)	
Reviewing Agency:	Manatū Hauora
Panel Assessment & Comment:	The Regulatory Impact Statement meets the quality assurance criteria.

Section 1: Diagnosing the policy problem

Context behind the policy problem

Under the BORA and the COVID-19 Act, the Government has a responsibility to ensure its response to the COVID-19 pandemic remains effective, justified and proportionate and avoids, mitigates, or remedies the actual or potential adverse effects of the COVID-19 outbreak.

A PHRA carried out on 26 January 2023 considered whether any changes are required to current COVID-19 policy settings. The measures in question are established by the Self-isolation Order and the Masks Order.

The PHRA was based on recent data about the progress of the pandemic and modelling of likely future developments and on input from community sources.

How is the status quo expected to develop?

Cases have decreased since the last PHRA on 22 November 2022. The key measures of COVID-19 infection used to monitor the pandemic including levels of viral RNA in wastewater, and reported case rates are decreasing, having peaked in mid-December 2022. It is unknown if this will continue, plateau, or increase in the following months.

Hospital admission rates also peaked in mid-December, while mortality counts have decreased and are tracking significantly below what was modelled.

Experience to date shows that these detection measures tend to lag changes in infection rates. The current trends are likely to be influenced by a combination of:

i. A change in behaviour patterns over summer with people more likely to gather and spend time outside rather than inside
ii. Schools being closed from mid-December to the end of January
iii. A change in testing and reporting habits over the summer break
iv. The community's level of immunity to the prevalent variants.

Since the last PHRA, cases, hospitalisations and mortality have all fallen to the lower points of the modelling. However, as of 22 January 2023, reinfection rate is up to 39.5% of cases and the size, timing, and duration of the current dip in new baseline trends of cases, hospitalisations and mortality is uncertain.

China is now reporting a large increase in case numbers and deaths due to COVID-19. At this stage none of the variants emerging are considered high risk. However, there is a lingering concern about the emergence of a new variant, creating uncertainty in predicting case and hospital trends.

What is the policy problem or opportunity?

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

In December 2022, Cabinet decided to retain Government-mandated seven-day isolation for cases and mask requirements for visitors to healthcare services. This decision was made in the context of emerging subvariants and rising case numbers, suggesting that New Zealand would experience a continued increase of cases in 2023. As these measures impose limitations on the rights of New Zealanders, the need for retaining them must be regularly reviewed.

As noted above, there is significant uncertainty when predicting case and hospital trends. While we are currently seeing declining cases it is hard to know how long this will last for. A

further consideration is that we are finishing the summer holiday period and returning to regular behavioural patterns. Over mid-December and January we have seen lower than expected cases as people were more likely to gather outside, more people were away from work, and schools were shut. Current rates of infection may be artificially low due to the holiday period. It is likely that rates of infection could rebound once more normal patterns of mingling (e.g. in workplaces, public transport, and education settings) resume.

The broad policy choice for the Government at present is whether strong guidance or government-mandated measures are the best way to encourage public health behaviour that minimise the spread of the virus. Under the COVID-19 Act, public health advice must be considered in making this choice, but Ministers may also consider social, economic and other factors.

There are two remaining mandatory measures that are under consideration, isolation of positive cases and the wearing of masks by visitors in healthcare settings. Based on preliminary analysis, the practical choices arising out of the January 26 PHRA have been narrowed down to the following:

Isolation

- Retain the status quo of mandatory 7-day isolation for cases; or
- Retain the status quo but add a 'test to release' option after 5 days of isolation; or
- Remove mandatory isolation for cases and move to guidance only for cases.

Masks

- Retain the Masks Order requiring people visiting healthcare services wear face masks; or
- Remove the Mask Order requiring people visiting healthcare services wear face masks.

Discussion - mandatory self-isolation for cases

Isolation of cases remains the cornerstone of New Zealand's public health response to COVID-19. It significantly limits the transmission of COVID-19 by reducing the proportion of infectious people having contact with and infecting others in the community, including vulnerable populations. Without government mandated isolation for cases, it is highly likely that adherence to guidance would be lower, resulting in an overall increase in transmission and case rates.

Overseas evidence suggests that a legal requirement to isolate results in significantly greater adherence than a recommendation to isolate. Experience when other mandates (e.g., masks) have been removed in New Zealand supports the view that adherence to guidance is typically much lower than to mandates. However, given that cases may be unwell from the symptoms of COVID-19, there may be higher adherence to self-isolation guidance than for other measures.

Discussion - Mask for visitors to healthcare services

Evidence that wearing a face mask decreases the rate of COVID-19 community transmission (and other airborne respiratory viruses) is substantial. Overseas evidence suggests mandates increase adherence, are associated with reductions in COVID-19 case and mortality growth rates. Further, the timing of when face mask mandates are applied is also important: early application is associated with a reduction in cases and mortality rates.

Health service settings have characteristics that elevate the risk of transmission and/or the risk of severe disease. These settings and the services provided within these settings are more likely than other settings to have people present with undifferentiated viral illness, either

because they are seeking help for symptoms or because they have a co-existing medical emergency. Further they are more likely to have vulnerable people present, either due to disability, advanced age, underlying conditions, or to being unwell at the time. Face mask requirements ensure that people who are at higher risk can access health services without avoidable additional risk.

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

Stakeholders

The ongoing response to COVID-19 affects everyone in Aotearoa New Zealand, however certain groups are more at risk due to clinical or equity-based reasons. The response also requires ongoing support from business and communities to ensure the public health response remains effective. In seeking to remain proportionate, we continue to balance public health risk against the need to minimise any compulsory measures and any associated impost.

Public Health Risk Assessment

Officials from Whaikaha and Te Aka Whai Ora contributed the vulnerable group perspectives through the PHRA process. Officials were able to draw on community views in making representations over the course of the PHRA.

Transport

Te Manatū Waka (Ministry of Transport) has consulted with Auckland Airport, Qantas and Air New Zealand on the option of test to release after day 5 of isolation. All operators were in favour of the proposal citing current staff shortage and the frustration of having their staff have to isolate for 7-day periods even if feeling healthy.

Further adding to the concern is the recent floods in Auckland which has caused significant disruptions and delays for carriers operating in Auckland. There is now a significant backlog of flights with passengers stranded, and the air sector is looking to a relaxing of the isolation requirements to help resolve this issue.

It is unclear how many staff a change to test to release from day 5 onwards would be able to return to the work force sooner.

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

Across the health system, Māori and Pacific peoples are more at risk of negative health outcomes than other population groups on an age-comparable basis and are also more likely to experience greater disease exposure. Similarly, those experiencing socio-economic disadvantage are at greater risk of severe negative health outcomes than other people of the same age and are also more likely to experience greater disease exposure.[1]

COVID-19 is no exception to these disparities. The burden of COVID-19 does not fall equally, and some people are at higher risk of adverse health outcomes from the virus. Changes to protection measures could disproportionately affect population groups such as older people,

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

disabled people and tāngata whaikaha Māori, Māori, Pacific peoples and some ethnic communities. At a high level, population agencies have noted that:

- Retaining public health measures aimed at limiting the spread of COVID (such as masking or self-isolation requirements) will benefit older New Zealanders. Case isolation requirements remain the most effective measure to reducing transmission of COVID-19 and therefore reducing inequities.
- Disabled people and tāngata whaikaha Māori have experienced an exacerbation of existing inequities throughout the COVID-19 pandemic. Retaining mandatory self-isolation provides protection for disabled people and give disabled people the confidence to participate in activities outside their home.
- Continued self-isolation requirements alongside other supports for Māori including access to sick leave and sanitation supplies to prevent further transmission in households.
- Retaining self-isolation aligns with their strategic priority of resilient health communities, laid out in the Pacific Aotearoa Lalanga Fou report.[2]
- Any changes need to consider the individual needs of whānau who are engaged in the corrections and wider justice systems.

Other population and sector impacts include:

- Te Arawhiti, Te Puni Kokiri, Ministry for Pacific Peoples, Whaikaha, Oranga Tamariki, and the Department of Corrections explicitly supported continuation of the requirement to isolate. Each agency has noted the ways in which their respective population groups were more vulnerable, and concern at the potential impact of removing isolation.
- The Ministry of Education noted that it supported decisions relating to isolation continuing to be health-led. They also advise that tertiary providers are mindful of their health and safety obligations and would prefer not to have to impose their own restrictions if there were no Government requirements in place. Providers have indicated that they would prefer to have a clear government mandated restriction for longer, than to have frequent changes or have to impose their own restrictions.
- The Ministry for Ethnic Communities did not explicitly support a particular option but noted potential benefits and concerns. The Ministry of Housing and Urban Development did not support a particular option, but noted a concern in relation to the possibility that increased cases might place further pressure on northern region providers.
- The Ministry of Transport (MoT) has provided feedback that case isolation requirements are impacting on existing workforce shortages across the aviation sector which are already under significant pressure. The recent weather events in Auckland have resulted in additional significant disruptions to the aviation system. MoT reports that the aviation sector would support a reduction in the period of mandatory isolation to 5-days. The Public Service Commission had no feedback from a public service perspective but sought clarification on the criteria for removing mandatory isolation.

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

[2] https://www.mpp.govt.nz/assets/Reports/Pacific-Aotearoa-Lalanga-Fou-Report.pdf

Given the broad implications of COVID-19 requirements and consistent with the requirements in the COVID-19 Public Health Response Act 2020, we need to consider public health implications, BORA implications and Te Tiriti o Waitangi and equity implications.

BORA and other legal implications:

The BORA implications for the proposed measures are considered in the multi-criteria analysis.

Self-isolation

s 9(2)(h) [redacted]

s 9(2)(h) [redacted]

Mask Requirements

s 9(2)(h) [redacted]

s 9(2)(h) [redacted]

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

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

Te Tiriti o Waitangi implications are discussed below in this RIS.

Outline the key assumptions underlying your understanding of the problem

The key assumptions underlying the approach to the problem taken in this RIS:

- The Government has a legal responsibility to manage the response to COVID-19, within the framework established by the COVID-19 Act and BORA considerations.
- The Government has a legal responsibility to ensure that the response to the pandemic is effective, justified and proportionate.
- In carrying out its legal responsibility, the Government must take account of public health advice, and may take account of other relevant social and economic considerations.

What objectives are sought in relation to the policy problem?

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

The overall objectives are:

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

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

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

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

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

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

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

Compliance - expected public compliance with measures (noting that this would only be used where compliance is relevant.

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

What scope will options be considered within?

Options are considered within the scope of:

a) The Government's responsibility to manage the response to COVID-19, within the framework established by the COVID-19 Act (including BORA considerations).
b) The current context of the pandemic, as identified by public health analysis and advice.
c) Other social and economic considerations relevant to the Government's response to COVID-19.
d) The current legislative framework for the Government's response to COVID-19, although modifying the framework remains an option.

Analysing the proposals

Proposals for different options for each of the measures considered are included below, together with analysis, including public health advice and multi-criteria assessment.

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

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

1. The 7-day case isolation requirement

Counter-factual and proposal

▪ Option 1	▪ Option 2	▪ Option 3
Status quo: the current requirement that cases self-isolate for 7 days remains in place to support the ongoing isolation of cases, to prevent spreading COVID-19 outside the household.	Remove mandatory 7-day self-isolation. Cases would be managed under the existing practices for notifiable diseases.	The status quo but positive cases can test to release after 5 days of isolation.

- **Public Health Risk Assessment**

PHRA recommendation	Maintain the current requirement that cases self-isolate for 7 days, until there is robust evidence to support removing it. Isolation of infectious cases to reduce community transmission remains an important way to suppress transmission of COVID-19 and help to minimise numbers of cases, hospitalisations, and deaths. It is likely that a shift from mandatory self-isolation to voluntary self-isolation supported by guidance would result in an increase in community cases. This increase would affect some communities and population groups more than others. It is highly likely that, if mandatory self-isolation were replaced with guidance, the resulting increase in cases would have disproportionate impacts for vulnerable communities, including Māori, Pacific and people with disabilities.

- **Multi-criteria assessment**

Criteria	Option 1: (Status quo) retain 7-day mandatory self-isolation requirements for cases	Option 2: removing mandatory self-isolation for cases and replacing with guidance to self-isolate	Option 3: Mandatory isolation with test to release from day 5
Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and	+/- • Making self-isolation in situ mandatory for cases, with tightly restricted exceptions, is one of the fundamental protections against the spread of COVID-19 deployed by	-- • This approach is likely to lead to significantly higher numbers of cases, hospitalisations, and deaths. • Modelling carried out in September 2022 estimated that removal of	- • This approach is likely to lead to higher numbers of cases, hospitalisations, and deaths. • Modelling carried out in September 2022 estimated within the first

hospitalisations) upholds BORA considerations	the Government in response to the current pandemic. This overall approach is considered a proportionate response to the COVID-19 pandemic, although restrictions of BORA rights are involved. • Modelling carried out in September 2022 suggested that the current mandatory isolation policy is preventing approximately 35-65,000 additional cases, 280-470 new hospitalisations and 35-60 additional deaths, over the next 45 days. Over a year, it is estimated to prevent approximately 1000 hospitalisations and 300 deaths.[3]	mandatory case isolation, in addition to the changes to face masking and household contact quarantine requirements made in September 2022, would result in approximately 35-65,000 additional cases, 280-470 new hospitalisations and 35-60 additional deaths, over the next 45 days.	month of shifting to test to release there'd be an increase in hospitalisations by roughly 45 to 640 and increase deaths by 6 to 120.
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- • The ongoing use of self-isolation is likely to maintain current levels of economic impact. • The economic impact of CPF Orange (as a proxy was estimated at 1%-2% of GDP in aggregate, $105m per week, with the most significant impact being from self-isolation of cases and their household contacts. • There are wider impacts that are felt across education, health, and other	+ • Removing mandatory case isolation may provide an economic benefit compared to the status quo by reducing unnecessary isolation days and easing businesses' staffing shortages in a tight labour market. However, most cases who are isolating are unwell (as asymptomatic cases are unlikely to test or know they are cases).	+ • Reducing the length of mandatory case isolation may provide an economic benefit compared to the status quo by reducing unnecessary isolation days and easing businesses' staffing shortages in a tight labour market. Any positive economic impact will be small if those isolating are predominantly those who are unwell and unable to return to work.

[3] The modelling referred to in the **Proportionality** section was carried out by COVID-19 Modelling Aotearoa. The modelling was based on data from before the emergence of the current wave and was based on an assumption that there would not be a further wave in the near future, or indeed within the next year. It is also noted that these results do not account for the multiple variants present in New Zealand. The September 2022 modelling therefore is likely to understate the positive impact of mandatory self-isolation on COVID-related health outcomes.

	critical services, and on wider society. It's important to note that these impacts will decrease as overall case numbers decrease.	Shortening or removing the isolation requirement would have a small impact on staffing shortages, because most cases are not fit to return to work until after the 7-day period has been completed.	
Equity - Evidence of the impacts of the measures for at risk populations	+/- • Maintaining these requirements reduces the number of potential cases, hospitalisations and deaths, particularly for communities who are at greater risk.	- • Vulnerable communities will experience disproportionate health impacts as a result of increased transmission. • In the absence of a government mandate for self-isolation, cases may be coerced or pressured to return to work by their employer, even if not fully recovered. This could have implications for both personal and public health.	- • Vulnerable communities will experience disproportionate health impacts as a result of increased transmission. • Those who cannot afford to miss time off work, who are disproportionately Māori and Pacific will be able to return to work sooner.
Compliance- expected public compliance with measures	- • There is evidence that compliance with this requirement is likely to decline over time and may already be declining. However, even after factoring in such a decline, compliance is likely to be higher than if Option 2 were adopted.	-- • Accurate domestic data on the behavioural impact of shifting from mandatory isolation to guidance is lacking. However, data from the UK infection survey suggests that there were lower rates of adherence to guidance in the UK. This suggests potentially larger increases in cases and hospitalisations could arise from such a change.	-- • Reducing the minimum time for self-isolation and introducing a 'test to release' option is likely to decrease the level of compliance, as people may choose to ignore their test result or not test after the minimum isolation period, even if the change was supported by public education and communications. • This measure is likely to see confusion in the community about when they need to isolate.

			• Potential for it to result in employees being pressured back to work before they are ready to do so.
Overall	- • Given the potential public health impacts, this remains effective, justifiable and proportionate at this time. It will be critical that this remains under regular review to ensure the measure remains proportionate to the risks posed by the current COVID-19 outbreak in New Zealand.	---- • Moving from mandatory self-isolation to guidance at this time is likely to increase the public health risk.	--- • Moving to 5 day test to release at this time is likely to increase the public health risk.

2 Mandatory face masks for visitors in health settings

Options

Option 1	Option 2
Status quo: Face masks are mandatory for visitors in health service settings including primary and urgent care, pharmacies, hospitals, aged residential care, disability related residential care, allied health and other settings	Removing the Masks Order and instead provide guidance to wear masks in health settings.

Public Health Risk Assessment recommendation

PHRA recommendation	Maintain the current requirement that masks are mandatory for visitors to health service settings. Masks are proven to be an effective measure to reduce the spread of COVID-19. Health care settings contain uniquely vulnerable groups, including sick, elderly, and disabled, making any COVID transmission high risk. • It is likely that a shift from mandatory to voluntary masks in healthcare settings would see a significant reduction on the use of facemasks as we have seen when previous face masks requirements have been removed. This would increase the health risk to many of the most vulnerable.	

- **Multi-criteria assessment**

Criteria	**Option 1: Status quo –** Face masks are mandatory for visitors in health service settings	**Option 2:** Removing the Masks Order and instead provide guidance.
Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds BORA considerations	+/- • Mandatory masks in health service settings protects people who are suspectable to catching COVID-19 and most likely to have worse outcomes. Feedback from two districts in late 2022 noted possible links between visitors and hospital-acquired cases of COVID-19. • Throughout the pandemic hospital-acquired COVID-19 infections are more likely to have poorer health outcomes than community-acquired infections. • Individuals need to access healthcare means people often do not have a choice in whether they access a health service.	- • The proposed measure would most likely see an increase in COVID-19 transmission at hospitals, aged care residents and disabled residential care.

Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- • Keeping transmission of COVID-19 low at health services is important in keeping the public's confidence in the health system.	- • There is a staff shortage across health, aged and disabled care services. Measures which increase the infection rate in these facilities put further stress on these systems.
Equity - Evidence of the impacts of the measures for at risk populations	+/- • Maintaining these requirements reduces the number of potential cases, hospitalisations and deaths, specifically in the disabled and elderly communities.	- • COVID-19 transmission will likely go up in health service settings. This will be a particular risk in aged care and disabled residents.
Compliance - expected public compliance with measures	+/- • Adherence to face mask requirements appears to be waning in some health service settings, the more normalised COVID is in the community the less measures are followed, even when required.	- • Removing the Mask Order would likely see a significant drop off in compliance to government guidance. When other mask mandates have been removed there has been a significant drop in compliance with guidance. This was most pronounced when the mandatory masks on public transport were removed.
Overall	+/- • Given the potential public health impacts, the Masks Order remains effective, justifiable, and proportionate at this time. As it is a mandatory measure in response to the COVID-19 outbreak it is critical that this remains under regular review to ensure it is required and proportionate.	---- • Removing the mask mandate would increase the public health risk. This increased risk would primarily affect the most vulnerable in our community.

Equity analysis

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

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

Reducing mandated public health measures may lessen the impact of public health measures on choice, economic stability and experience of inequity due to enforcement systems. However, it has the potential to increase the inequity associated with co-morbidities or other health conditions that exacerbate the effect of contracting the virus, for example leading to self-imposed isolation, or an increased chance of hospitalisation or needing medical intervention.

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

We have relied on the broader feedback that has been provided on the COVID-19 response to date, including through surveys, specific reviews and through representative groups and stakeholder forums. Due to time constraints, further comprehensive consultation has not been completed with Māori and Pacific Peoples to inform the equity analysis.

Equity analysis for Māori

The COVID-19 outbreak has worsened already inequitable health outcomes experienced by Māori. The mandatory measures in place have sought to minimise and protect priority populations from COVID-19.

Among Māori over the age of 18, 86.8 percent are at least partially vaccinated, and 56.3 percent of Māori who are eligible for first boosters have received them. While there are high vaccination rates for at least one dose, booster vaccination uptake could be improved among Māori. Particular consideration of accessibility to tools that prevent risks of transmission or severe disease will be considered for iwi; an example of this is the increased availability of medical masks to marae, kaumatua facilities, and Māori vaccination providers.

Māori continue to have the one of the highest hospitalisation rates compared to other ethnicities, after standardising by age. Aged standardised COVID-19 attributed mortality rates are 1.8 times higher among Māori, compared to European and other ethnicities.

Equity analysis for Pacific peoples

Pacific Peoples continue to be disproportionately affected by COVID-19 in addition to long-standing inequitable health outcomes and service use. Recent data shows that Pacific Peoples are significantly overrepresented in all of the negative COVID-19 health statistics.

Among Pacific Peoples over the age of 18, 91.7 percent are at least partially vaccinated (compared to 91.5 percent across all ethnicities) and 61.2 percent of eligible Pacific peoples

have received at least one booster dose (compared to 73.1 percent across all ethnicities). There is more work to be done in encouraging booster vaccination uptake among Pacific peoples to mitigate the impact of the predicted rise in case numbers over the summer.

Pacific peoples continue to have the highest hospitalisation rate compared to other ethnicities, after standardising by age. As of 16 January 2023, COVID-19 attributed mortality rates are also 2.3 times higher among Pasifika, when compared to European and other ethnicities, after standardising by age.

Equity analysis for older people

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

Equity analysis for disabled people and tāngata whaikaha Māori

The Human Rights Commission's report Inquiry into the Support of Disabled People and Whanau during Omicron found that lessening restrictions led some disabled people to choose to isolate themselves, leading to feelings of isolation and stress and a restriction on their own freedoms for the benefits of others.

Disabled people who receive the Disability Support Services Payment have a hospitalisation risk that is approximately four times higher than the general population. Further, rates of COVID-19 attributed mortality are approximately 1.5 times higher among this group compared to the rest of the population.

The continuation of measures, particularly face masks requirements for people accessing medical services, provides people with disabilities some, albeit little, reassurance. The absence of mask requirements in environments such as public transport causes anxiety and additional risk for disabled people, particularly those with underlying co-morbidities.

Equity analysis for other/all groups

The most deprived populations continue to have the highest rates of hospitalisation, and have twice the risk of hospitalisation, compared with those who are least deprived. Those who live in crowded housing, especially Māori, Pacific peoples, and some ethnic communities for example, living in an intergenerational arrangement, or those who work in particular roles such as hospitality or retail, are also likely to be more at risk of transmission.

Broadening the essential permitted movement of cases to allow them to return to their primary place of residence will enable cases visiting family living in crowded housing to return home to isolate and protect their vulnerable family members. It also eases the monetary burden on those who are most deprived who would otherwise be forced to pay for additional accommodation so that they can complete their self-isolation in situ.

Retaining the 7-day self-isolation period ensures that cases belonging to vulnerable groups, who may otherwise face pressure or coercion from their employers to return to work, can refer to the mandated self-isolation period as a reason they cannot leave isolation. This allows them to rest and recover, which reduces the immediate and long-term health impacts of their infection. It also prevents the case from infecting family, friends and colleagues, who may also belong to vulnerable groups. On the other hand, there are some equity concerns that retaining mandated 7-day isolation prevents people in high-deprivation from returning to work and earning money, and further, that this may jeopardise their employment.

Removing mandatory case self-isolation and switching to isolation guidance only would result in much lower compliance with self-isolation advice. The long-term consequences of COVID-

19, including Long COVID, which disproportionately impacts vulnerable groups such as Māori, Pacific Peoples and people with disabilities, would increase as cases do not rest and recover when they are ill. Transmission would increase, putting vulnerable populations at even greater risk than they face under the status quo settings. Removing mandatory self-isolation, however, represents a significant reduction of rights-limiting measures imposed on cases, but in the current context these limitations are justified.

Te Tiriti analysis

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

In December 2021, the Waitangi Tribunal's Haumaru: COVID-19 Priority Report states that Te Tiriti obliges the Crown to commit to achieving equitable health outcomes for Māori, and that doing so only along with commitments regarding other ethnicities is insufficient; specific focus must be granted to achieving equitable outcomes for Māori. The report found that the Government was failing to meet Te Tiriti obligations, in particular with the rollout of the vaccinations programme, and that this failure would result in disproportionate and lasting impacts of Long COVID on Māori.

The Māori Protection Plan's two key drivers are critical to ensuring that response initiatives continue to have a positive impact for Māori, including the ongoing Winter Package measures. This includes free medical and N95 masks, greater access to antivirals for those that are eligible by prioritising equitable access for Māori alongside other eligibility criteria, and COVID-19 and flu vaccinations.

Targeted engagement has been undertaken with Māori stakeholders on the changes being assessed in this regulatory impact statement: with the National Iwi Charis Forum, representatives of non-affiliated iwi and Māori leaders who are part of RLGs. In addition, Māori health representatives taking part in the PHRA expressed strong support for each of the changes assessed in this regulatory impact statement.

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

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

The overall assessment arrived at through the analysis presented in this RIS supports the following recommendations:

a) Retain mandatory self-isolation for COVID-19 cases.
b) Retain mandatory face masks for visitors to healthcare services

Section 3: Delivering an option

How will the new arrangements be implemented?

The recommended settings are already in place. It is anticipated that the Minister of Health will make any announcements following consideration by Cabinet.

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

As noted above, the Government is required under the COVID-19 Act to monitor and review mandatory public health measures. This includes monitoring of case numbers, hospitalisations, international trends to identify variants of concern, along with wastewater and other surveillance activities. Trends in case numbers, hospitalisations and mortalities are compared by ethnicity and deprivation. The results of this monitoring and surveillance is compiled into a weekly insights report (as well as other ad hoc reporting) to help inform decision making.

The next scheduled PHRA is planned for March 2023.