CAB-23-MIN-0136

Cabinet

Minute of Decision

COVID-19 Public Health Measures

Portfolio **Health**

On 11 April 2023, following reference from the Cabinet Social Wellbeing Committee, Cabinet:

1 **noted** that since October 2022, the following COVID-19 requirements have been 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;

1.3 regulation of COVID-19 point-of-care tests;

2 **noted** that there is an authorisation under 8(c) of the COVID-19 Public Health Response Act 2020 (the Act) in force to authorise the making of COVID-19 orders for self-isolation of cases, masks for visitors to health care settings, and point-of-care tests regulation until 28 April 2023;

3 **noted** that the Prime Minister has received advice on extending the expiry date beyond 28 April 2023;

Review of case isolation requirements

4 **agreed** to retain the status quo of seven-day mandatory self-isolation for COVID-19 cases (Director-General of Health recommended);

Review of government mandated mask requirements

5 **agreed** to retain the COVID-19 Public Health Response (Masks) Order;

Review of regulation of point-of-care tests for COVID-19

6 **agreed** to revoke the COVID-19 Public Health Response (Point-of-care Tests) Order 2021 (Director-General of Health recommended);

7 **noted** that four weeks' lead time would be required for operational reasons;

Next steps

8 **noted** that Cabinet's decisions will be announced following agreement;

9 **noted** that COVID-19 response settings will be reviewed again in May 2023;

10 **noted** that while these measures will be kept under review, the current expectation is that they will likely continue to be required over winter;

11 **agreed** that there will be a clear signal on an exit strategy at the appropriate time.

Rachel Hayward
Secretary of the Cabinet

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 – that cases isolate for 7 days, and that visitors to health service settings be required to wear masks. This paper also recommends that regulation of point-of-care tests for COVID-19 be revoked, as it is no longer necessary.

Relation to government priorities

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

Executive Summary

3. A public health risk assessment was carried out on 16 March 2023 to review the appropriateness of settings. This process leads to the development of public health advice from the Director-General of Health (see Appendix One), which supports the requirement under section 14(5) of the COVID-19 Public Health Response Act for the Minister to keep all measures under review.

4. The current set of public health measures – both mandatory and non-mandatory – form a pragmatic approach to managing COVID-19. These measures are intended to reduce risk of transmission, encourage testing, maintain high vaccination coverage, provide a system of care including antivirals for those at higher risk, communicate to the public, and maintain ongoing surveillance.

5. 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:

    a. retaining mandatory isolation of cases for 7 days;

    b. revoking mandatory use of masks for visitors to health services;

    c. revoking regulation of the import, manufacture and supply of point-of-care COVID-19 tests.

6. I support the Director-General's recommendation to retain mandatory case isolation for 7 days and revoke the Point of Care Test Order. However, I am

also seeking to retain the requirement that visitors to health service settings wear masks. Under section 9 of the COVID-19 Public Health Response Act, I must have regard to advice from the Director-General, but I am not required to follow that advice.

7. As New Zealand approaches the winter illness season it is critical that the public health response remains effective in limiting the spread and impacts of COVID-19 infections. The health system is already under more pressure than is typical at this time of year compared to other years during the pandemic. Increases in the spread of COVID-19 worsens this pressure and restricts the ability of the health sector to deliver services to both COVID-19 and non-COVID-19 patients.

8. COVID-19 continues to affect some population groups significantly more than others. Specifically, older people, Māori, Pacific Peoples, and disabled people are at higher risk of severe outcomes.

9. Health service settings have a series of characteristics that elevate the risk of transmission and/or the risk of severe disease. People with hospital-acquired COVID-19 infections are more likely to have poor outcomes compared with people with community-acquired infections. The need to access healthcare means that people often have no choice but to be in that setting. Maintaining the mandatory use of masks for visitors helps to reduce the risk of COVID-19 transmission in these settings.

10. The Crown's obligations to Māori under Te Tiriti o Waitangi requires 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. In assessing proportionality, it is important to recognise that due to Te Tiriti o Waitangi more restrictive measures may be required to achieve these objectives.

11. In this context, retaining the mandatory requirements for cases to isolate and for visitors to health service settings to wear masks remains necessary – in addition to non-mandatory measures – to continue to suppress 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 manageable.

12. As required under the COVID-19 Public Health Response Act, these measures will remain under review, to ensure that the requirements remain proportionate and justified. However, I consider it likely that these measures will remain in place over winter. Ministers will continue reviewing the measures through this period, and may consider removing them in spring, after receiving public health advice.

Context

Status of the COVID-19 outbreak

13. Since the last Public Health Risk Assessment (PHRA) for COVID-19 on 26 January 2023, there has been a slight increase in case rates over late February and they have stabilised over the week ending 12 March. Hospital admissions have increased. Deaths have been relatively stable for the past few weeks. Reported case rates are currently similar to the rates between the August and December COVID-19 waves. The 7-day rolling average of reported cases was 1,593 in the week to 19 March.

14. The continued evolution of incrementally more immune evasive variants generates an upward pressure on transmission, without necessarily corresponding to a distinct 'wave' of cases. The current expectation is that cases will continue to oscillate over the coming year, without as substantial an impact on hospitalisations as seen in 2022.

XBB is now the most common variant in the community

15. The most common variant of Omicron, according to wastewater-based epidemiology is now XBB, a subvariant that has grown considerably from 2% in late January to making up 43% of infections by 12 March. CH.1.1 is the second most prevalent variant, accounting for 28% of infections, followed by BA.2.75 (including XBF) at 25%[1].

COVID-19 continues to have disproportionate impacts on certain population groups

16. There are still significant differences in the rate of severe illness from COVID-19 between different population groups.

    a. The cumulative total age-standardised hospitalisation rate to 12 March 2023 shows that Pacific peoples and Māori have had the highest risks of hospitalisation for COVID-19: 2.3 and 1.8 times the risk of European or Other, respectively.

    b. A recent review found that Disability Support Services (DSS) recipients have had 4.2 times the risk of hospitalisation when compared to the rest of the population during 1 January – 16 November 2022, and were 13 times more likely to die due to COVID-19. Further analysis undertaken by Whaikaha found that DSS recipients who receive residential support are 8 times more likely to be hospitalised than the general population.

    c. Older people are more likely to have severe illness than younger people. People aged 50 years and above have accounted for 650,865 cases (29% of total cases), of whom 2,547 have died (98% of total deaths) in the period to 20 March 2023.

[1] Variant prevalence is less impacted by flooding events than is the quantitation of viral material used to estimate total infection trends. Samples severely affected by flooding are excluded from both analyses. WGS tends to represent more severe cases (based primarily on clinical samples from hospitalised cases) and WBE tends to represent total infections. Both sources of data are broadly consistent, to date, with about a third of WGS cases identified as XBB in the week to 10 March.

Mortality rates for COVID-19 are likely to remain high relative to other causes of death

17. While vaccination and the 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 that year (378).

18. Based on deaths reported for the period from 1 January to 19 March 2023, if the number of deaths attributable to COVID-19 (186) continues at the current rate, this would result in 845 annual deaths, which is comparable to the annual number of deaths due to prostate cancer (709 in 2020), or breast cancer and melanoma combined (936 in 2020).

Te Tiriti o Waitangi

19. As described in paragraph 13, COVID-19 continues to have a disproportionate impact on Māori. This impact is evident in reported cases, hospitalisations, and deaths. It is reasonable to assume that Māori will also be disproportionately affected by long COVID.

20. The Crown's obligations to Māori under Te Tiriti o Waitangi requires 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 actively protect Māori from the direct and indirect impacts of COVID-19, and to partner with Māori to achieve this. This means that there is a need to consider the impact on, and perspectives of, whānau when making decisions that affect hauora Māori. This includes efforts to counteract inequitable health outcomes and prevent the impact of COVID-19 from falling disproportionately on Māori.

Current measures

21. As described earlier, the current set of public health measures – both mandatory and non-mandatory – form a pragmatic approach to managing COVID-19. These measures are intended to reduce risk of transmission, encourage testing, maintain high vaccination coverage, provide a system of care including antivirals for those at high risk, communicate to the public, and maintain ongoing surveillance.

22. In February 2023, Cabinet agreed to continue the following COVID-19 mandatory public health measures:

    a. 7-day self-isolation for cases; and

    b. mask requirements for visitors to healthcare services [CAB-23-MIN-0055].

23. In addition, the import, manufacture and supply of point-of-care tests for COVID-19 (eg rapid antigen tests) has been regulated since 2021, and to date its use has been linked to the requirement to isolate.

24. The use of orders for these purposes is currently 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 Act.

Legal framework to make orders under the Act

25. Under section 8 of the Act, COVID-19 orders may be made while there is an epidemic notice in force, a state emergency or transition period in relation to COVID-19 is in force, or if the Prime Minister, by notice in the *gazette*, after being satisfied that there is risk of an outbreak or the spread of COVID-19 has authorised the use of COVID-19 orders (either generally or specifically). s 9(2)(h) s 9(2)(h) [redacted] Advice on section 8(c) will be provided to the Prime Minister prior to Cabinet considering this paper, so that it is clear whether the use of orders remains possible.

26. Under section 9 of the Act, provided that one the prerequisites under section 8 have been met, the Minister of Health may make a COVID-19 order provided he or she:

    a. has regard to the advice from the Director-General of Health regarding the risks of the outbreak or spread of COVID-19, and the nature and extent of measures (whether voluntary or enforceable) that are appropriate to address those risks; and

    b. may have regard to any decision by the Government on the level of public health measures appropriate to respond to those risks and avoid, mitigate, or remedy the effects of the outbreak or spread of COVID-19 (which decision may have taken into account any social, economic, or other factors)

    c. must be satisfied that the order does not limit or is a justified limit on the rights and freedoms in the New Zealand Bill of Rights Act 1990;

    d. must have consulted the Prime Minister, and the Minister of Justice, and may consult with any other Minister he or she thinks fit

    e. before making the order, must be satisfied that the order is appropriate to achieve the purpose of the Act.

Self-isolation

27. Officials have analysed three options for ongoing self-isolation for cases:

    a. retain the status quo of 7-day mandatory self-isolation; or

    b. retain the status quo for people who are symptomatic, but enable people who are asymptomatic (symptomatic for 1 day or less) to leave isolation after 5 days; or

c. case isolation requirements are removed and replaced with clear guidance that people who test positive for COVID-19 should self-isolate for 7 days.

Public health advice

28. The Director-General recommends that the current government mandated 7-day case isolation requirement is retained. 7 days is likely the minimum threshold for self-isolation to remain an effective intervention. A shorter isolation period, combined with or without test-to-release, is not considered an effective intervention, as many people would still be infectious to some degree on release.

29. 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. This would lead to more infectious cases in the community, increasing overall infection rates, serious illness, hospitalisations and death.

30. A survey series commissioned by Manatū Hauora from September 2022 to February 2023 provides insight on current attitudes and actions in relation to the requirement for cases to isolate: while intention to self-isolate has remained high throughout this period; the proportion of people who test positive who also report isolating has dropped slightly to 67%.

31. Modelling provided by COVID-19 Modelling Aotearoa is not able to directly estimate the impact that removing mandatory self-isolation might have on cases, as there is limited data available in relation to several key assumptions.

32. However, modelling is able to provide an estimate of the potential impacts for a range of scenarios. Provisional modelling results provided by COVID-19 Modelling Aotearoa in March 2023 indicate that:

    a. A change to case isolation requirements that results in an increase in transmission of 10%, will cause an approximate 54% increase in peak bed occupancy in hospitals in the 26 weeks following the change. This equates to an additional 233 hospital beds at peak occupancy (range 95-287).

    b. A change in case isolation requirements that results in transmission increasing by 15% will cause an approximate 88% increase in peak bed occupancy in hospitals over the 26 weeks following the change. This equates to an additional 382 hospital beds at peak occupancy (range 179-463).

Potential health sector impacts

33. I am concerned at the potential impact that removing mandatory isolation could have on the health sector. 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.

34. When the requirement for cases to isolate was removed in other countries, it has often been followed by an increase in hospitalisations. However, it is not possible to attribute these increases to the policy change given the cyclical nature of COVID-19 waves. Figure 1 shows COVID-19 hospital inpatients per capita in the UK (mandatory isolation removed 24 February 2022); figure 2 shows COVID-19 hospital inpatients per capita in Australia (mandatory isolation removed 14 October 2022).

Figure 1: Number of COVID-19 patients in hospital per million people from 1 Jan 2022 – United Kingdom

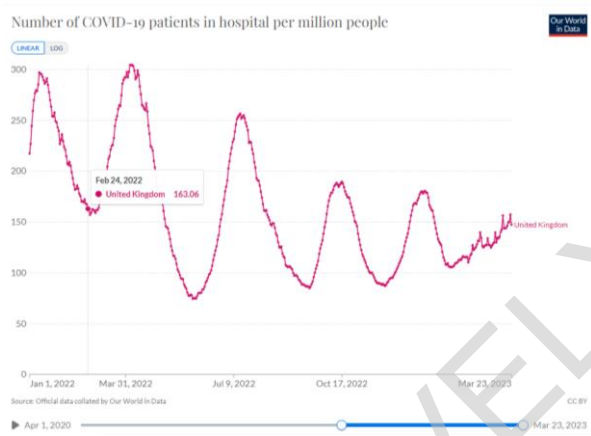
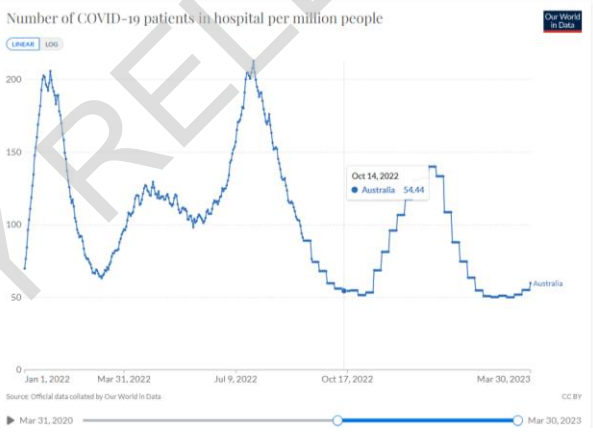


Figure 2: Number of COVID-19 patients in hospital per million people from 1 Jan 2022 – Australia



Population impacts

35. 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, and that there is also an acknowledged differential exposure to COVID-19 risk related to socioeconomic status. If there are more infectious people circulating in a community with more baseline contacts, this increases the likelihood of onward transmission.

36. Feedback from agencies on further population and sector impacts is included in Appendix 2.

Economic impacts

37. The Treasury considers that shifting from an isolation requirement to guidance (option three) 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.

38. Previous modelling has suggested that a test-to-release policy (two negative tests to release with a five-day minimum, seven-day maximum isolation

period) would only result in 2-3% more cases being released while infectious, but up to one fewer day spent in isolation per case. This would have a positive economic impact through reducing excess isolation days in a tight labour market.

39. Allowing those symptomatic for one day or less to leave isolation after five days (option two) may also have an economic benefit compared to the status quo by reducing the time spent in isolation for those otherwise well enough to work.

40. However, with all these scenarios, there are potential countervailing factors that could affect the observed economic impacts. These are difficult to quantify, but include:

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

    b. An increase in overall infections causing additional people to be too unwell to work (although test-to-release guidance could help mitigate this).

41. COVID-19 Modelling Aotearoa have noted that if isolation requirements are to be removed, removing them when infections are low will result in a smaller short-term increase in infections (and therefore have smaller workforce impact) than removing the requirements when infections are already increasing (e.g. due to a new variant).

42. However, the Treasury considers that as the current requirement only applies to those who return a positive test result and is unenforced, a shift to guidance may only have a minor impact on the extent to which people isolate. If so, the economic impact of a change will be negligible. Financial support to isolate may be having more of an impact on the extent to which people isolate than the requirement itself.

43. Therefore, shifting to guidance for self-isolation (option three), reducing isolation requirements for asymptomatic individuals (option two), or moving to test-to-release policy (either under a requirement or guidance) may have positive economic impacts compared to the status quo (option one) by reducing worker absences, but the actual economic impacts may in practice differ due to the countervailing factors discussed above.

Impact of removing mandatory self-isolation on various support schemes

44. 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)

45. The COVID-19 Leave Support Scheme would continue to be available for employers under this scenario. The cost of the LSS has reduced in line with the reduction in case numbers, with $12.3 million paid out in February 2023 (compared to $180 million paid out in March 2022). Over $9.5 million had been paid out in March 2023 (as at 22 March).

46. If the scheme remains operational, current funding is likely to be sufficient to last until the end of the financial year. The Treasury and MSD are providing advice to the Minister of Finance and the Minister for Social Development and Employment on options to fund the scheme beyond the end of this financial year.

47. The LSS will continue to be paid out for those legally required to self-isolate. When the legal requirement to self-isolate is removed, cases will no longer be eligible to receive support through the LSS. This would mean there would no longer be government support to business for the cost of people (voluntarily) isolating.

48. Te Aka Whai Ora notes that this will have a greater impact on Māori workers (and other groups) who are more likely not to have access to paid sick leave entitlements or be in a weak bargaining position with their employer and therefore may be more exposed to pressure not to use entitlement that they technically have. Removal of the LSS would contribute to greater inequity in the harm caused by COVID-19.

Care in the Community welfare response (CiC)

49. CiC Welfare Response community supports (Food and Community Connection Service) for isolating households will not be operationally impacted by option 1 or 2 isolation settings as they operationally equivalent.

50. Under all settings COVID-19 cases will continue and there will be some groups still detrimentally impacted by COVID-19 that will seek welfare support from the system and create additional demand for community based social services.

Operational considerations

51. Feedback from agencies on operational considerations is included in Appendix 3.

Point of care tests

52. The importation, manufacture, supply, sale, packaging, and use of point of care tests (such as RATs) is regulated under the COVID-19 Public Health Response (Point-of-care Tests) Order 2021 (POCT Order). The POCT Order is a regulation that restricts the importation and supply of a POCT (including RATs) unless provided an exemption from the Director General of Health.

Public health advice

53. The POCT Order was originally enacted under the elimination strategy where a single positive test could lead to rights-limiting requirements such as self-isolation or a lockdown, and therefore the risk of a false negative or positive result was of high concern.

54. The Director-General recommends that retention of the POCT Order is no longer considered appropriate because:

    a. false positive and negative test results no longer pose a significant risk as the COVID-19 management strategy has changed, the public is not required to use Government funded tests, and the market is already saturated with approved tests, and

    b. the quality control of COVID-19 testing products can be carried out via a procurement process, rather than a separate regulation such as the Order, and through other existing regulatory mechanisms such as the Consumer Guarantees Act 1993.

55. Te Whatu Ora have noted that there are some operational implications of removing the order, which would require a lead time of four weeks.

Masks in health service settings

56. 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 health services.

57. The Director General recommended revoking the Masks Order. I am however proposing to retain this requirement, as face masks remain important tools to reduce risk of transmission in health service settings. Health service settings have a series of characteristics that elevate the risk of transmission and/or the risk of severe disease.

58. This measure will be kept under review over winter. I have instructed officials from Manatū Hauora and Te Whatu Ora to ensure appropriate infection, prevention and control plans are in place at the point the mandate may be removed. This work is underway.

Public health advice

The Director-General has recommended that the Masks Order be revoked once Te Whatu Ora and Manatū Hauora implement national infection prevention and control (IPC) guidance, before the Order is revoked, to support stakeholders to manage risk levels on their premises. The Director-General believes that the impact of replacing the visitor mask mandate with a facility policy approach on both overall transmission and on populations more at-risk from COVID-19, is likely to be low. She notes that the current mandate applies only to visitors, is poorly adhered to in many settings, and does not provide flexibility to vary according to current epidemiological circumstances.

Population impacts

59. Most population agencies explicitly opposed the removal of the visitor mask mandate from health service Those agencies were concerned at the potential for adverse impacts on vulnerable populations if the mandate was removed.

60. Appendix four includes further details of these population impacts.

Operational considerations

61. Health officials are working on national guidance that provides key principles and considerations to enable facilities /policy makers or specialist groups responsible for this area to enable national consistency, but some flexibility given the different services, risks and needs within facilities that provide healthcare.

Economic impacts

62. The Treasury does not consider that current mask requirements have any measurable economic impact.

Consultation

63. This paper was prepared by Manatū Hauora. The following agencies were also consulted: 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 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, WorkSafe, the Treasury, Whaikaha – Ministry of Disabled People.

Financial Implications

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

Legislative Implications

65. The recommendations in this paper involve the following legislative implications:

    a. if current settings for self-isolation are retained, there are no legislative implications for the Self-isolation Order;

    b. if requirements for visitors to wear masks in health service settings are retained, there are no legislative implications for the Masks Order;

    c. if regulations in relation to the importation, manufacture, supply, sale, packaging, and use of point of care tests for COVID-19 are assessed as no longer necessary, the POCT Order would need to be revoked.

66. 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. The current notice expires on 28 April 2023. The Prime Minister has received advice regarding the extension of the authorisation.

Impact Analysis

67. 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.

Human Rights

s 9(2)(h) [redacted]

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

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

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

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

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

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

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

s 9(2)(h) [redacted]

Masks [legally privileged, Crown Law advice]

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

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

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

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

Communications

79. I will announce decisions on this paper following Cabinet agreement.

Next steps

80. If Cabinet agrees to revoke the POCT order, Manatū Hauora will prepare drafting instructions for the Parliamentary Counsel Office (PCO). PCO would then prepare a draft revocation order for the Minister to sign.

81. Unless there is a significant change in COVID-19 risk, any remaining government-mandated measures will be reviewed again in May 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

82. 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:

1.1 Seven-day mandatory self-isolation for cases; and

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

1.3 Regulation of COVID-19 point-of-care tests.

2 note that there is an authorisation under 8(c) of the COVID-19 Public Health Response Act 2020 (the Act) in force to authorise the making of COVID-19 orders for self-isolation of cases, masks for visitors to health care settings and point-of-care tests regulation until 28 April 2023;

3 note that the Prime Minister has received advice on extending the expiry date beyond 28 April 2023;

Review of case isolation requirements

4 agree to retain the status quo of 7-day mandatory self-isolation for COVID-19 cases (Director-General of Health recommended);

Review of government mandated mask requirements

5 agree to retain the COVID-19 Public Health Response (Masks) Order;

Review of regulation of point-of-care tests for COVID-19

6 agree to revoke the COVID-19 Public Health Response (Point-of-care Tests) Order 2021 (Director-General of Health recommended);

7 note that four weeks' lead time would be required for operational reasons.

Next steps

8 note that decisions on this paper will be announced following Cabinet agreement;

9 note that COVID-19 response settings will be reviewed again in May 2023;

10 note that while these measures will be kept under review, the current expectation is that they will likely continue to be required over winter.

Authorised for lodgement

Hon Dr Ayesha Verrall

Minister of Health

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

Appendix 2: Proposal to retain requirement to self-isolate – population and sector impacts

1. Te Aka Whai Ora supports the retention of mandatory case isolation, and notes that 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 who are more likely to be in precarious employment, with less access (or no access) to paid sick leave, or where there is a greater power imbalance with their employer.

2. Te Puni Kokiri supports the retention of the 7-day isolation period to ensure that whānau with COVID-19 can fully recover from the ailment. Also, the isolation period is a safe measure in ensuring that community cases are low. If the isolation period is reduced or removed, this could have a big impact on small-medium enterprises – including Māori SMEs. It is also possible that a reduction in the isolation period could pressure infected people into returning to work/school before they are fully recovered – this could lead onto an increase in community cases.

3. Te Arawhiti supports the retention of case isolation and notes that 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. Given the negative impacts that repeat infections may have on immune systems, the need for case isolation requirements is heightened.

4. The Ministry for Pacific Peoples notes that Pacific peoples are more vulnerable to COVID-19 risk-factors, and anticipates that Pacific peoples will continue to experience a greater burden from the ongoing health and economic consequences of COVID-19. Given the risk factors that Pacific peoples are subject to, and the burden that COVID-19 has had on Pacific peoples to date, the Ministry supports options that best protect the health and wellbeing of Pacific peoples, whilst balancing other economic and social considerations.

5. Whaikaha supports the retention of mandatory case isolation, and notes that COVID-19 has exposed the existing inequities that disabled people face in their everyday lives, and many existing inequities for disabled people and their whānau have been exacerbated. Disabled people experience particular risks associated with co-morbidity of health conditions. Given international and domestic evidence shows disabled people experience disproportionately high mortality and infection rates, some disabled people report that they continue to be fearful of leaving their homes, even for essential services. The lack of feeling safe is as relevant as being safe and will impact behaviours. Ensuring mandatory self-isolation of 7 days for positive cases will help mitigate against further impacts on community participation.

6. Oranga Tamariki supports the retention of mandatory case isolation as a key protective mechanism, particularly for vulnerable communities. There is good evidence of its effectiveness and provides it certainty.

Sector and workforce impacts

7. The Tourism group from the Ministry of Business, Innovation, and Employment (MBIE) does not have a preferred option, but notes that the self-isolation requirement can be problematic for international visitors. Over time this is likely to increase the attractiveness of other destinations that don't have these requirements relative to New Zealand which will have an economic impact (it is very hard to estimate this given all the other disruptions/factors influencing international travel). The MBIE Tourism team also notes that the FIFA Woman's World Cup will be held in NZ and Australia in July/August, and forecast visitor numbers will mean that this is a much busier winter than usual. The high profile nature of this event may mean that more public attention is given to this issue.

8. The Ministry of Transport (MoT) notes similar concerns in relation to the FIFA Women's World Cup. In addition, MoT notes that case isolation requirements are impacting on existing workforce shortages across the aviation sector which are already under significant pressure. The aviation sector would support a reduction in the period of mandatory isolation to 5-days, 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.

9. Based on the experiences in jurisdictions where the mandatory requirement to isolate has been removed, it does not appear that this has had a significant positive impact on workforce availability. The critical issue from a public health perspective is whether someone is likely to be infectious, not whether they are symptomatic. If people return to school or work while still infectious, this is likely to lead to further transmission to others present in that setting. Increased infections have costs in the acute phase (with other employees unable to work due to sickness), but also in the post-acute phase due to long COVID.

10. The Regulatory Impact Statement provides further details of feedback from agencies.

Appendix 3: Proposal to retain requirement to self-isolate – operational considerations

1. The Ministry of Education has noted that if the mandate was removed, they would need public health advice on appropriate timeframes for staff and students to stay at home.

    a. For early childhood education services, COVID-19 would need to be added to regulations that outline exclusion periods for common communicable diseases (Education (Early Childhood Services) Regulations 2008, Regulation 57[2]).

    b. There is no equivalent regulation for schools, although a principal of a State school may preclude a student from school if they have reasonable grounds to believe that the student may have a communicable disease within the meaning of the Health Act.

    c. Tertiary providers have previously signalled concerns regarding risks of increased transmission amongst staff and students if mandatory isolation was to be removed. These concerns will be significant amongst vulnerable or immune-compromised staff and students, including disabled people, and older staff and students. There may also be concerns about impact for Māori and Pacific students and staff and their whānau and families. Tertiary providers have previously signalled that they would prefer not to have to impose their own restrictions where there are not 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.

2. Ara Poutama has noted that their approach to date has been focused on minimising transmission of the virus, particularly in prisons, to protect staff and any clinically vulnerable people they manage. If mandatory isolation was removed, Ara Poutama would likely continue to provide support for frontline staff to encourage them to stay home when COVID-19 positive. Ara Poutama would likely continue to isolate prisoners who are cases away from the rest of the prison population to reduce the risk of transmission using provisions within the Corrections Act 2004.

3. The Ministry of Justice noted that retaining the 7-day isolation requirement will have an impact on court delays/timeliness due to staff sickness and matters being adjourned/rescheduled, though measures can be taken to minimise disruption.

4. The New Zealand Police did not identify any significant impacts.

[2] Education (Early Childhood Services) Regulations 2008, Regulation 57 is focused on the health and safety of children. The criteria are based on the Regulations and set out the day-to-day standards that services must follow in order to retain their licence or certificate. There are different criteria for different service types (for centre-based education and care services, home-based, hospital-based education, kōhanga reo, and playgroups). https://www.education.govt.nz/early-childhood/licensing-and-regulations/the-regulatory-framework-for-ece/#Regulations https://www.education.govt.nz/early-childhood/licensing-and-regulations/the-regulatory-framework-for-ece/#Regulations

5. Employment Services have noted that clarity about public health advice will be important for employees and employers if isolation requirements are removed. For example, employees are likely to raise issues with being in the same workplace as a co-worker or anyone who has COVID-19. The more room for interpretation left by guidance, the greater the potential grounds for disagreement between employers and employees (or PCBUs and workers, from a work health and safety perspective). WorkSafe supports this view, and has noted that it would need to prepare some standard messages in anticipation of these types of queries once decisions are taken. The Ministry of Transport has noted that if the isolation requirement was removed, there would need to be clear guidance for symptomatic cases to isolate, and this should also clarify what makes a case ‘symptomatic’.

Appendix 4: Proposal to remove requirement for visitors to wear masks in health service settings – population impacts

1. Te Aka Whai Ora does not support the removal of mandatory face mask requirements, due to the potential for adverse impacts this would have on Māori who already suffer disproportionate health outcomes.

    a. Te Aka Whai Ora noted that there is currently insufficient information available to properly assess the likely impact of changes to public health restrictions, such as mask requirements in healthcare settings. It is not sufficient for the Crown to rely on whole-of-population data or modelling to determine the appropriateness of changes to public health restrictions that may have a disproportionate impact on Māori. Without an appropriately thorough evidence base about the impact of policy settings on Māori, it is not possible to make an assessment of the effectiveness of those settings (such as a mask mandate) or the impact on Māori if they were to be changed.

    b. For this reason, Te Aka Whai Ora recommends making no changes to public health restrictions until a more thorough assessment can be undertaken. Te Aka Whai Ora considers that, in the absence of an adequate analysis of the impact of potential changes to public health restrictions on Māori, it is not appropriate for the Government to make a decision to change the existing restrictions around the use of masks in healthcare settings or self-isolation of COVID-19 cases.

    c. Te Aka Whai Ora notes that COVID-19 remains a significant issue for Māori, accounting for 4% of all Māori deaths in New Zealand in 2022.[3] Māori (and Pacific) peoples have more than twice the risk of death from COVID-19 compared to European and Other groups.[4]

2. Te Puni Kokiri does not support the removal of the mask mandate for visitors to health service settings. Aligned with the concerns and issues identified by Te Aka Whai Ora, Te Puni Kokiri believes that this could have negative impacts on vulnerable communities, immune compromised whānau, and Māori who are overrepresented in negative health statistics. Te Puni Kokiri supports the recommendation made by Te Aka Whai Ora that no changes should be made within this area until a thorough assessment has been conducted.

3. Whaikaha does not support removal of the visitor mask mandate. The Office for Seniors also notes concerns about the removal of a mask mandate for visitors to health service settings, especially aged residential care. Whaikaha notes that even with the current mandatory settings in place, DSS recipients who receive residential support are 19% more likely to report a positive COVID-19 test result, 8 times more likely to be hospitalised and 47 times more likely to die with or of COVID-19. Whaikaha has also noted that any change in these data that might arise from adopting a policy-based approach

[3] This is based on a comparison of Māori deaths reported by Stats NZ in *Monthly death registrations by ethnicity, age, and sex: January 2010 to December 2022*, and Māori deaths reported in 2022 by Manatū Hauora as attributable to COVID-19.
[4] https://www.health.govt.nz/publication/covid-19-mortality-aotearoa-new-zealand-inequities-risk

to visitor mask use has not been quantified. Whaikaha recommends that decisions to remove mandatory face mask requirements are not made until such a time that regular data is collected on DSS recipients' COVID-19 outcomes.

4. The Office for Seniors notes that older people are at heightened risk of adverse impacts resulting from COVID-19 infection, especially those with additional overlapping vulnerabilities such as other health conditions. A reduction in mask-wearing by visitors to health settings could result from removal of these restrictions. The Office notes that there is insufficient evidence presented to determine the risk of infection and adverse reactions among older people as a result of this change.

5. The Office notes that for some older people there is likely to be a heightening of concern about COVID-19 infection for older people in places they are living (for those in aged residential care) or visiting for necessary medical treatment. These concerns are justifiable in light of the significantly greater risks that COVID-19 infection poses to older people, as well as instances of COVID-19 spreading through aged care and similar facilities in New Zealand and overseas during the earlier stages of the pandemic. If a decision is made to remove the mask mandate investment should be made in public health messaging recommending mask wearing in certain circumstances. The Office considers that the appropriate place of mask-wearing within public health measures needs to be normalised in such settings.

6. The Ministry for Ethnic Communities notes that continuation of the status quo may give some reassurances to some ethnic communities who are vulnerable to COVID-19 such as the elderly and those with an underlying health condition(s).

7. Oranga Tamariki notes many of the concerns raised by other population agencies above. In addition, Oranga Tamariki also noted potentially reduced protection for children and young people (particularly those more vulnerable due to being unvaccinated), increased tension and confusion for caregivers/parents/guardians around using masks in healthcare settings (eg,. differing opinions between caregivers and parents). Oranga Tamariki notes that removal of this measure may increase the risk of children and young people spreading COVID-19 to more vulnerable people in their communities.

8. Oranga Tamariki also notes that if this measure was removed, they would support the proposed mitigation – i.e. "clear guidance for health service providers". However, Oranga Tamariki suggested this is expanded on .if possible to give further assurance – e.g. in line with Te Whatu Ora feedback which states that the guidance should include "a national document that provides key guiding principles and considerations to enable facilities /policy makers or specialist groups responsible… to enable national consistency, but some flexibility given the different services, risks and needs within facilities that provide healthcare".

Memo

COVID-19 Public Health Risk Assessment – 16 March 2023

Date:	22 March 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 16 March 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 focus of the PHRA Committee (the Committee) meeting on 16 March was to assess the current public health risk arising from COVID-19 in Aotearoa New Zealand based on data and recent model outputs. Having received advice from the Committee, the Director of Public Health recommends the following:

1. 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	**Revoke** the current face mask mandate in health service settings, once Te Whatu Ora and Manatū Hauora implement national infection prevention and control (IPC) guidance, before the Order is revoked, to support stakeholders to manage risk levels on their premises
Rationale for the decision and any additional comments	To move away from broad health sector wide emergency measures will move some of the responsibility back to health care providers. This enables providers to create bespoke policies to best cater to their respective

	communities and the community risk at the time. It also allows for consistent mask polices across patients, staff and visitors. Committee members from Te Aka Whai Ora did not support the removal of mandatory face mask requirements, due to the potential for adverse impacts on Māori who already suffer worse health outcomes. Similarly, Whaikaha members did not support removal of the visitor mask mandate, noting that even with the current mandatory settings in place, DSS recipients who receive residential support are 19% more likely to report a positive COVID-19 test result, 8 times more likely to be hospitalised and 47 times more likely to die with or of COVID-19. *The Director of Public Health acknowledges differences of opinion among the Committee members and the concern regarding a lack of Māori and disability-specific data. However, there was no immediate prospect of providing the required data to address the acknowledged uncertainties in the timeframe available. The Director of Public Health notes it will be important to ensure that national guidance on mask use addresses the concerns raised by Te Aka Whai Ora and Whaikaha.*

2. 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.
Rationale for the decision and any additional comments	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. Retaining case isolation will support ongoing mitigation of disproportionate impacts on vulnerable populations, provide lead-in time for the bivalent rollout to take effect and to manage potential pressures impacting on the health system as we head into winter. *There was broad support among Committee members for retaining the 7-day case isolation requirement.*

3. Point of Care Test Order

Current requirement	Regulation of COVID-19 test products.
Director of Public Health recommendation	**Revoke** the Point of Care Test Order.

Rationale for the decision and any additional comments	To increase the proportionality of COVID-19 measures because: 1. false positive and negative test results no longer pose a significant risk as the COVID-19 management strategy has changed, the public is not required to use Government funded tests, and the market is already saturated with approved tests, and 2. the quality control of COVID-19 testing products can be carried out via a procurement process, and through other existing regulatory mechanisms such as the Consumer Guarantees Act 1993 *The Director of Public Health outlined the recommended change to the Point of Care Test Order and the rationale for the change. The committee was not asked to provide further comment, noting that a separate consultation process with the COVID testing team has already provided advice.*

Background

3. 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.

4. 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 change 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.

5. 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.

6. The Government's response is based on a mix of mandatory and non-mandatory measures, focused on increasing immunity through access to vaccination and antivirals; incentives for people to stay home when they have COVID-19; and ensuring the ongoing protection of priority and at-risk populations. This includes proactive service delivery and targeted communications to increase the level of reach and uptake of measures amongst these communities.

7. 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. When assessing proportionality, it is important to account for the objectives of both Te Tiriti o Waitangi and equity considerations as less proportionate, more restrictive measures may be required to achieve these objectives.

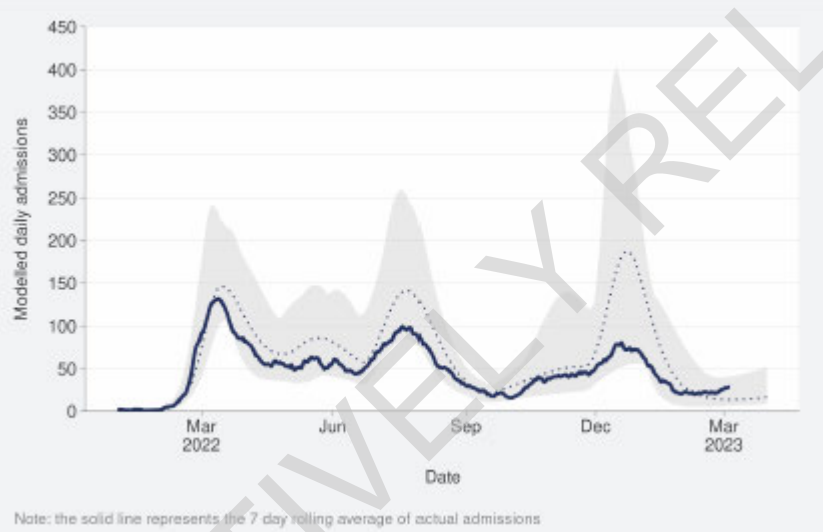
Summary of outbreak status and epidemiological context

COVID-19 case rates have stabilised but hospitalisations have increased

8. Overall, the key measures of infection (levels of viral RNA in wastewater and reported case rates) used to monitor the COVID-19 epidemic remain stable compared to the last PHRA in January 2023 in most regions after increasing slightly in late February 2023.

9. COVID-19 related hospital admission rates have increased in the week ending 5 March 2023, following the recent slow increase in cases in late February, and are tracking in the upper bound of the 95% confidence interval (figure 1). Hospitalisations that are classified as being 'for COVID-19' are higher than the incidental rate. Since October 2022, COVID-19 related hospital admissions of patients admitted for COVID-19 related illness were 1.8 times higher rather than those admitted who incidentally had COVID-19.

Figure 1 - COVID-19 Modelling Aotearoa hospitalisation scenarios compared with national through 12 March 2023[1]



Vulnerable populations have the highest rates of hospitalisation

10. There are differences in the rates of hospitalisation by ethnic group. The cumulative total for the year shows that Pacific peoples and Māori have had the highest risks of hospitalisation for COVID-19 – 2.3 and 1.8 times the risk of European or Other, respectively. In the week ending 5 March, Māori had the highest age adjusted admission rate (0.9 per 100,000).

Figure 2 – COVID-19 daily age standardised hospital admissions for COVID-19 per 100,000 population through 12 March 2023

11. Further, a review of people with disabilities' experience of COVID-19 [HR2022017250 refers] found that Disability Support Services (DSS) recipients have had 4 times the risk of hospitalisation when compared to the rest of the population during 1 January - 16 November 2022. Further analysis undertaken by Whaikaha found that DSS recipients who receive residential support are 8 times more likely to be hospitalised.

There is a slower but steady uptake of the second booster

12. The first booster has seen a steady uptake with 71.5% of the eligible population having received their first booster. The second booster has seen a slower but steady rise in uptake with 49% 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 but the proportion of XBB cases is growing quickly

13. The continued evolution of incrementally immune evasive variants generates an upward pressure on transmission, without necessarily corresponding to a distinct 'wave' of cases. There is a range of variants in the community with no one variant being dominant. The most common variant in wastewater (which reflects community infections) is XBB, a subvariant that has grown considerably from 2% in late January to now making up 43% of community cases, followed by CH.1.1, which now accounts for 28% of cases in the community. The next most prevalent are other BA.2.75 (including XBF) at 25%.[2]

Risk assessment

Cases rates have stabilised

14. Since the last PHRA, case rates rose slightly over late February and stabilised over the week ending 12 March. Modelling undertaken in late 2022 suggests that, assuming no substantial policy or other changes, this will continue into April, but the modelling is uncertain because it 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.

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

Variants of concern

16. The proportion of Omicron sub-variant XBB.1.5 cases in the community has grown to 22% in cases that are whole genome sequenced. 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.

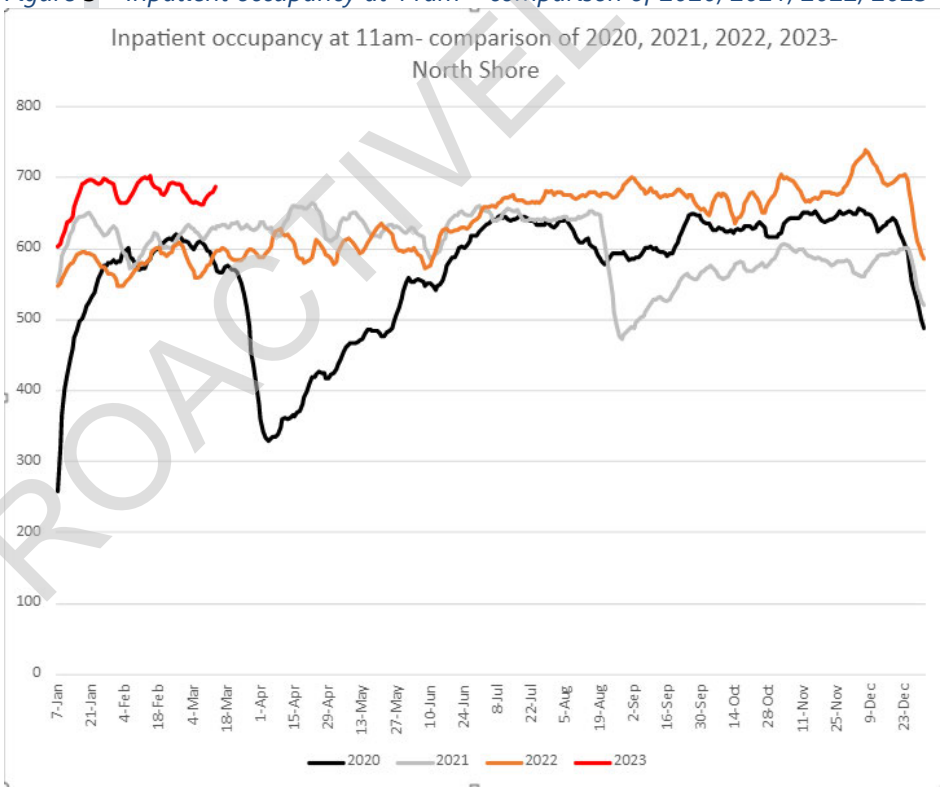
Uptake of therapeutics

17. Uptake of COVID-19 therapeutics has been steadily increasing over recent months, and uptake is high among vulnerable populations. Approximately half of Māori and Pacific Peoples aged 50-64 years who report positive tests were accessing antivirals in the week ending 5 March. 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.

The health sector is under pressure

18. The health sector is under significant pressure and this is restricting delivery of critical health services to patients. For example, at North Shore hospital inpatient occupancy from the start of 2023 to 18 March 2023 is tracking well above that of the same period in 2022, 2021, and 2020 (figure 3).

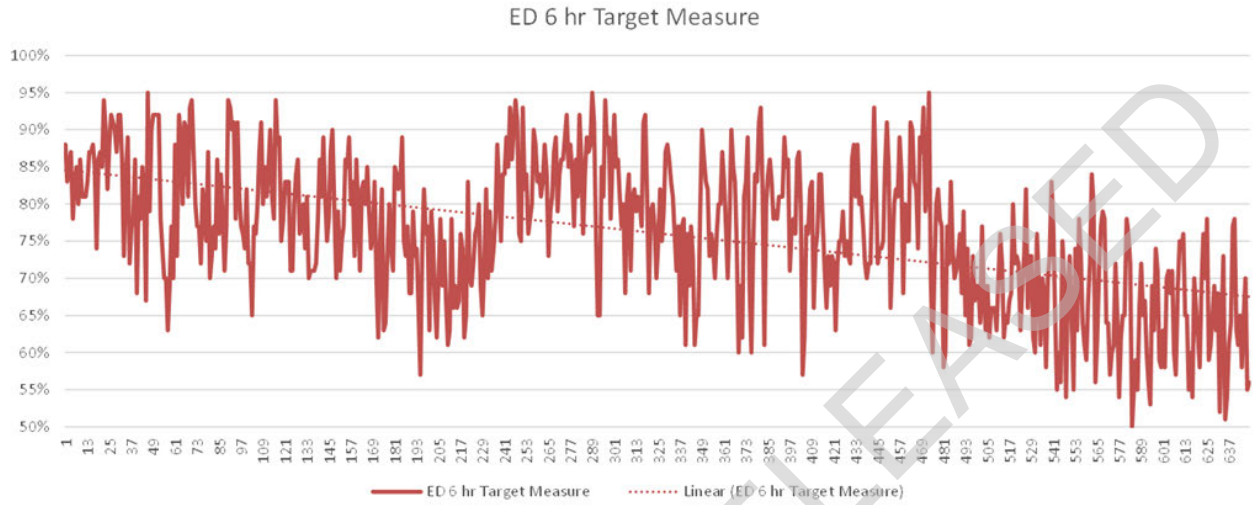
Figure 3 – Inpatient occupancy at 11am – comparison of 2020, 2021, 2022, 2023 – North Shore Hospital



19. Further, over the last year Middlemore hospital has recorded over 100 days where it was over 95% occupied for combined adult medical and surgical beds. Further, from 1 January

to 9 October 2022, Middlemore hospital emergency department struggled to meet its 6-hour target measure for ED admissions (figure 4).

Figure 4 – Middlemore Hospital emergency department 6-hour target measure performance 1 January – 9 October 2022



20. The health and disability sector capacity will be put under considerable strain if COVID-19 hospitalisations continue to increase as Aotearoa New Zealand moves into the winter illness season.

Director of Public Health comment on current risk from COVID-19 to the New Zealand population

21. 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 to the population overall remains low but is increasing. The risks to more vulnerable members of the population remain higher than for the general population but may be reducing with the commencement of bivalent vaccine and extensive use of antivirals.

The basis for recommendations on current measures within this context

22. As Aotearoa New Zealand approaches the winter illness season it is critical that the public health response remains effective in limiting the spread and impacts of COVID-19 infections. As noted in paragraphs 17-18, the health system is already under much higher pressure than is typical at this time of year compared to other years during the pandemic. Increases in the spread of COVID-19 worsens this pressure and restricts the ability of the health sector to deliver services to both COVID-19 and non-COVID-19 patients.

23. It is also important that vulnerable groups are well protected, particularly until the Government rolls out the bivalent booster dose to vulnerable populations and can monitor its uptake. Ensuring that vulnerable populations can receive the booster before self-isolation requirements are lifted, protects both the wellbeing of those vulnerable to COVID-19 and health system capacity.

The ability to make Orders under section 8(c) of the COVID-19 Response Act – are extraordinary powers still required to manage the outbreak?

24. Whilst not an issue specifically considered at the PHRA, the relatively stable situation may make it difficult to continue to justify the maintenance of the section 8(c) for the making of COVID-19 Orders. The authorisation expires on 28 April 2023.

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

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

Comment on key non-mandatory measures

27. With daily case numbers staying relatively constant over recent weeks, rising hospitalisations and high pressure on health sector capacity, the risk posed by the virus to many groups within the population remains significant.

28. Uptake of the first booster is stable at 71.5%, and uptake of the second booster uptake has risen slightly to 49% of the eligible population. The bivalent booster has become available to eligible members of priority groups from 1 March 2023, and it becomes available to those aged 30 years and over on April 1. The bivalent booster provides targeted protection against Omicron subvariants, which is important for protecting vulnerable people and health sector capacity as Aotearoa New Zealand moves toward the winter illness season with an Omicron 'variant soup'.

Summary of Committee deliberations of case isolation requirements

29. Case isolation remains the most effective measure to reduce the onward transmission of COVID-19. The requirement to isolate as a case is a significant imposition on a person's right to freedom of movement. Recent World Health Organisation (WHO) patient management guidelines have also noted that risks of transmission from asymptomatic cases are considerably lower than from those with symptoms.

30. The degree to which retention of an order requiring isolation contributes to the actual isolation behaviour of cases may be changing over time. Limited data from a behavioural insights survey in February suggests that actual isolation following testing positive is decreasing (67%) but numbers included in the survey were small. It is noted that there is no legal requirement to either test or report results of tests although the ongoing provision of leave support and antivirals may be incentivising both testing and reporting. It should be noted that modelling results (provided in appendix 1) do not explicitly incorporate any changes in behaviour but rather provides a range of scenarios that could occur as a result of isolation behaviour change.

31. Despite these limitations in the evidence base, the Committee was reluctant to remove or reduce the current 7-day case isolation requirement. As detailed in Appendix One, other factors factoring into these deliberations are:

    a. Modelled increases in transmission following the removal of the mandate.

    b. International and domestic experience showing reduced adherence, but inconclusive results regarding infection rates if the mandate is removed.

    c. Limited benefits in the reduction of the isolation period for asymptomatic cases.

    d. The potentially disproportionate impact on vulnerable populations.

Considerations if the requirement to isolate is not maintained

32. Regardless of the recommendations in the public health advice the Director-General of Health will provide to the Minister of Health, there is a possibility that the requirement to

isolate may be removed – for example, if the test in section 8(c) of the Act cannot be met, or if the Minister and/or Cabinet does not support the recommendations.

33. If this occurs, there is a need to ensure that there is a smooth transition to a new approach. There are also a set of actions that could be undertaken to mitigate the effects of removing the mandate. If the isolation mandate is removed, I would recommend the following measures:

    a. Clear guidance that cases should isolate for 7 days.

    b. Maintain guidance and functionality to report COVID-19 test results – this information (even if not capturing all cases), still provides important information on case trends to assist health service planning and is also the main mechanism for identifying people requiring support and/or likely to be eligible for antivirals.

    c. Establish a mechanism to ensure cases are aware of the recommended isolation period including advice that they may be directed to isolate by a Medical Officer of Health should a failure to isolate place vulnerable persons at risk.

    d. Continue the Leave Support Scheme (LSS) – potentially in a more targeted form as has been used in other jurisdictions. This would support people who might otherwise find it difficult to isolate to do so.

    e. Strengthen effective public health measures that do not involve limitations on individual rights – for example, systemic improvements to ventilation in high-risk settings.

    f. Consider whether eligibility for antivirals should be further expanded.

34. In addition, I note that we have received feedback previously from other agencies regarding their concerns if isolation were to be removed:

    a. Some population groups are more at risk of severe outcomes than others, and that removing mandatory isolation may have impacts for these groups in terms of their ability to take part in daily activity and social interactions. This is particularly likely to be the case where there are not other safeguards in place – such as those outlined in para 33 above.

    b. If a change was to occur, 6 weeks would be required to make the necessary operational changes, such as updating providers on new advice, and reviewing collateral.

Summary of Committee deliberations of mask requirements

35. Masks are still considered an effective measure, particularly in protecting vulnerable populations. While data is limited, there is anecdotal evidence to suggest a degree of non-compliance in certain settings and fatigue within certain facilities. Furthermore, there are increasing calls for organisations to be able to develop their own policies to both manage the risk and respond to the needs of staff and patients specific to their context.

36. While there was limited support among Committee members for removing face mask requirements on public health grounds, some members expressed that the requirement that visitors wear masks is no longer proportionate. This is because compliance with the requirement is waning, and health providers can assess the risk levels unique to their premises and of enforcing their own policies on who should be wearing masks.

37. For example, enforcement of face mask requirements in non-hospital health settings such as pharmacies is challenging as it is not always 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.

38. Committee members from Te Aka Whai Ora did not support the removal of mandatory face mask requirements, due to the potential for adverse impacts this would have on Māori who already suffer disproportionate health outcomes. Committee members noted the lack of evidence specific to the likely impacts on Māori. Similarly, Whaikaha members did not support removal of the visitor mask mandate noting that even with the current mandatory settings in place, DSS recipients who receive residential support are 19% more likely to report a positive COVID-19 test result, 8 times more likely to be hospitalised and 47 times more likely to die with or of COVID-19. Any change in in these data that might arise from adopting a policy-based approach to visitor mask use has not however been quantified.

39. Whaikaha recommends that decisions to remove mandatory face mask requirements are not made until such a time that regular data is collected on DSS recipients' COVID-19 outcomes.

40. While there was limited support from Committee members to remove mandatory face mask requirements, there was broad support for extensive consultation of affected groups, and for implementing national IPC face mask guidance prior to removing the mandatory requirements, if the Minister decides to revoke the Order. Additionally, some members suggested that the Minister consider other alternatives besides only a switch to national IPC mask guidance.

41. It is important to note, however, that not all sectors or persons conducting affected businesses or undertakings will have the capacity or capability to do this themselves. Te Whatu Ora emphasises that when schools were asked to undertake their own risk assessments in line with guidance, it placed on them a significant additional burden and in many instances resulted in schools opting for no mask requirements to avoid this burden and conflict with their communities. This highlights the need for national IPC mask guidance to be comprehensive and effectively communicated if mask requirements are removed. There is currently IPC guidance for healthcare staff and patients provided by Te Whatu Ora however this does not extend to visitors to these facilities. Before removing the Mask Order, Te Whatu Ora and Manatū Hauora will need to provide clear and considered guidance on appropriate mask wearing procedures for each healthcare setting.

Director of Public Health comment on mask requirements

Taking the above discussion into account, the Director of Public Health's assessment is that the impact of replacing the visitor mask mandate with a facility policy approach on both overall transmission and on populations more at-risk from COVID-19, is likely to be low. The current mandate applies only to visitors, is poorly adhered to in some settings, and does not provide flexibility to vary according to current epidemiological circumstances. In making this assessment the Director is also cognisant of the concerns around harms from visitor mask requirements in some settings presented to the committee. The replacement of the mandate with clear guidance for health service providers is appropriate. It's important to note that the mandate does not cover the use of masks by healthcare workers, including in-home care and support workers, and much of the commentary

around the retention of masks relates to the general provision, rather than the sub-set (visitors) covered by the mandate.

Removing the point of care test Order

42. The point of care test Order (POCT Order) is a regulation that restricts the importation and supply of a POCT (including RATs) unless provided an exemption from the Director General of Health.

43. The POCT Order was originally enacted during the "Elimination" strategy where a single positive test could lead to rights-limiting requirements such as self-isolation or a lockdown, and therefore the risk of a false negative or positive result was of high concern.

44. The retention of the POCT Order is no longer considered appropriate because:

    a. false positive and negative test results no longer pose a significant risk as the COVID-19 management strategy has changed, the public is not required to use Government funded tests, and the market is already saturated with approved tests, and

    b. the quality control of COVID-19 testing products can be carried out via a procurement process, rather than a separate regulation such as the Order, and through other existing regulatory mechanisms such as the Consumer Guarantees Act 1993.

45. See Appendix 3 for further information on the removal of the POCT Order.

Equity and Te Tiriti o Waitangi considerations for maintaining measures

Impact of COVID-19 on vulnerable populations

46. 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 have decreased since the last PHRA and have remained stable over the last fortnight

47. COVID-19 attributed mortality rates are also higher among Pasifika (2x higher) and Māori (1.7x higher), compared to European or Other ethnicities.

48. The most deprived populations continue to have the highest rates of hospitalisation (0.7 per 100,000), almost double that of those who are least deprived (0.4 per 100,000). There is also an increased risk of COVID-19 attributed mortality for those in socio-economically deprived groups. The most deprived populations have 2 times the risk of mortality when compared with those in the least deprived population.

49. 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.

50. Many disabled people attend health care appointments and pharmacies for their medication and have expressed their preference that mask mandates are retained in health care settings, in particular pharmacy and primary care.

51. 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.[3 4 5 6 7 8]

Addressing equity concerns

52. 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.

53. Retaining 7-day self-isolation for cases limits the spread of COVID-19, and this allows time for the roll out and uptake of bivalent booster doses, increased access to therapeutics, and improvement of the diagnosis and treatment of long COVID to protect those who are most vulnerable to the impacts of infection.

54. The new COVID-19 response strategic framework sent to the Minister on 9 March [H2023021045] 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.

55. 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 51% of Māori cases and 50% of Pacific Peoples cases.

56. The Director of Public Health notes that the costs of measures may also be being borne disproportionately by disadvantaged groups who despite being eligible for leave support may have less secure employment and therefore be reluctant to take leave. Parents of test positive children may also be less likely to take parental leave to care for isolating children and isolating children from disadvantaged groups may be more vulnerable to educational disruption.

Equity considerations in these recommendations

57. 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.

58. Committee members highlighted the role that self-isolation plays in protecting vulnerable communities in Aotearoa New Zealand.

59. 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.

60. 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.

61. Subsequently, the recommendation to revoke the mask order is accompanied by a Manatū Hauora and Te Whatu Ora plan to develop IPC guidance to empower stakeholders in the health and disability sector to manage the risk levels relevant to their premises and roles, and a timeframe which allows them time to operationalise this guidance before a decision is made to revoke the mask order.

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, then 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)

s 9(2)(h)

64. s 9(2)(h)

65. s 9(2)(h)

66. s 9(2)(h)

67. s 9(2)(h)

s 9(2)(h)

68. s 9(2)(h)

69. s 9(2)(h)

70. s 9(2)(h)

Next steps

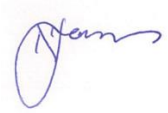
71. Pending your agreement, we will share this memo with the Minister of Health's Office and the Parliamentary Counsel Office.

72. If the Minister of Health approves the recommendations of this memo, Manatū Hauora will provide a paper to Cabinet by 11 April 2023, outlining these recommendations.

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.	Agree	to recommend that the Minister of Health remove current face mask requirements	Yes/No
4.	Agree	to recommend that the Minister of Health retains current case isolation requirements	Yes/No
5.	Agree	to recommend that the Minister of Health remove point of care test Order requirements	Yes/No
6.	Note	that the section 8(c) Prime Minister Authorisation Notice advice will be provided to the Prime Minister in parallel with the advice on these public health measures, and the Prime Minister's decision on that advice may limit the measures that can be used	Noted
7.	Note	that Manatū Hauora is working with Te Whatu Ora on developing national IPC mask guidance to coincide with a removal of the current face mask requirements	Noted
8.	Note	that the lead time for development of a consistent national infection prevention and control guidance/any subsequent workforce development is six weeks	Noted



Signature Date: 22 March 2023
Dr Nicholas Jones
Director of Public Health
Public Health Agency | Te Pou Hauora Tūmatanui
Manatū Hauora | Ministry of Health

Signature Date: 23 Mar 2023
Dr Diana Sarfati
Director-General of Health | Te Tumu Whakarae mō te Hauora
Manatū Hauora | Ministry of Health

Appendix One – Case Isolation

The potential impact of removing case isolation

73. Modelling suggests that removing mandatory requirements and switching to guidance on measures relating to household contact isolation and mask wearing on 12 September 2022 did impact 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. This is likely to have been due to the use of a more conservative assumption regarding community adherence than is likely to have been the case.

74. Provisional modelling results provided by COVID-19 Modelling Aotearoa indicate that:

a. changes to case isolation requirements (and other behaviour changes or measures) that result in a moderate increase in transmission of 10%, will cause an approximate 54% increase in peak bed occupancy in hospitals at some point in the 26 weeks following the change

b. changes in case isolation requirements (and other behaviour changes or measures) that result in a higher increase in transmission of 15% will cause an approximate 88% increase in peak bed occupancy in hospitals over the 26 weeks following the change.

Table 1. Model results for the short-term and long-term impact of ending mandatory COVID-19 isolation requirements. Differences in cumulative infections, COVID-19 hospital admissions, and COVID-19 deaths, in the 7 weeks and 26 weeks following the policy change, and peak hospital occupancy during the 26 weeks following the policy change, under three model scenarios (+5%, +10% and +15% change in transmission on 21 March 202). All results are relative to the baseline model with no policy change. In each table cell, the first line shows change in absolute numbers and the second line shows relative (percentage) change compared to baseline. Values in brackets represent the 95% confidence intervals on these differences.

Scenario	Short term impact Difference in cumulative numbers from 0 to 7 weeks post policy change			Long term impact Difference in cumulative numbers from 0 to 26 weeks post policy change			Difference in peak hospital occupancy in the 26 weeks post policy change
	Infections	Hospital admissions	Deaths	Infections	Hospital admissions	Deaths	
Lower (+5% on 21Mar23)	+83,000 [+32,000, +95,000] +27% [+25%, +29%]	+500 [+200, +600] +25% [+21%, +26%]	+23 [+12, +40] +15% [+12%, +16%]	+81,000 [+59,000, +88,000] +6% [+5%, +9%]	+700 [+400, +800] +7% [+6%, +11%]	+73 [+63, +135] +8% [+7%, +13%]	+103 [+30, +130] +24% [+12%, +26%]
Central (+10% on 21Mar23)	+179,000 [+73,000, +200,000] +57% [+52%, +65%]	+1,000 [+400, +1,300] +55% [+48%, +57%]	+51 [+27, +88] +34% [+26%, +36%]	+164,000 [+117,000, +176,000] +12% [+11%, +17%]	+1,400 [+700, +1,500] +15% [+13%, +21%]	+148 [+124, +269] +17% [+15%, +25%]	+233 [+95, +287] +54% [+37%, +57%]
Higher (+15% on 21Mar23)	+282,000 [+123,000, +308,000] +91% [+80%, +108%]	+1,700 [+700, +2,100] +90% [+82%, +96%]	+85 [+45, +145] +56% [+43%, +59%]	+247,000 [+174,000, +264,000] +18% [+16%, +24%]	+2,100 [+1,100, +2,300] +23% [+20%, +31%]	+225 [+185, +406] +25% [+23%, +37%]	+382 [+179, +463] +88% [+70%, +92%]

75. When interpreting these results, it is important to be aware of the following interpretation caveats:

a. It is not possible to determine the size of the effect that removing mandatory isolation would have on cases.

b. Modelling does provide a useful range of potential impacts under different scenarios. However, it is not a prediction, and results are reliant both on the model itself and the assumptions it uses.

c. The model assumes that there is no major new variant.

d. The model does not take into account use of anti-viral therapies and the impact that they may have on hospitalisations and deaths.

e. The baseline modelling scenario (that assumes no changes to isolation, and does not account for behaviour change over winter, or other changes) represents a long-term projection associated with approximately half as many deaths as occurred in the winter 2022 wave (1,929 attributable deaths occurred during the equivalent 26-week period in 2022, compared to 891 in the baseline modelling scenario). However, a winter model would likely predict a higher case load than the current baseline model, but not as high as the 2022 winter.

f. Modelling does not account for hospitalisations and deaths for other conditions and health events for which there are heightened risks following COVID-19 infection (for example, cardiovascular events[9]). It also does not include the impact of delayed care and/or workforce pressures on these metrics.

Are people who test positive isolating?

76. A survey series commissioned by Manatū Hauora from September 2022 to February 2023 provides insight on current attitudes and actions in relation to the requirement for cases to isolate:

    a. intention to self-isolate has remained high throughout this period – the percentage of participants reporting that they would be 'likely' or 'very likely' to isolate if they were a case was 83%, 85% and 85% in September 2022, November 2022, and February 2023 respectively;

    b. the proportion of people who test positive who also report isolating has dropped slightly (67% in the February 2023 survey compared to 78% in the November 2022 survey).

77. The Institute of Environmental Science and Research (ESR) has produced an exploratory estimate of the case ascertainment rate (CAR), based on comparing reported cases and wastewater results. However, as noted previously, CAR is an exploratory metric. Since this metric was first reported in late 2022, results have been more variable than expected. As a result, this metric is not currently considered sufficiently reliable.

What can we learn from the experience in other jurisdictions?

78. Evidence from overseas from early 2022 suggests that a legal requirement to isolate is likely to have significantly greater **adherence** than a recommendation to isolate. For example, in the United Kingdom, there was a significant drop in adherence 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.[10]

79. It is difficult to compare the impact that the removal of isolation mandates in other jurisdictions has on **infection levels**, as many countries also changed metrics relating to the level and/or severity of infection at the same time. In addition, changes to testing practices both in hospital and of people who have died (which may or may not have occurred at the same time as the removal of isolation) also have the potential to impact on hospitalisation and mortality data. For example, several states in Australia (VIC, NSW)

removed the mandatory requirement to report at the same time as the requirement to isolate was removed in October 2022, while ACT did not remove it until February 2023.

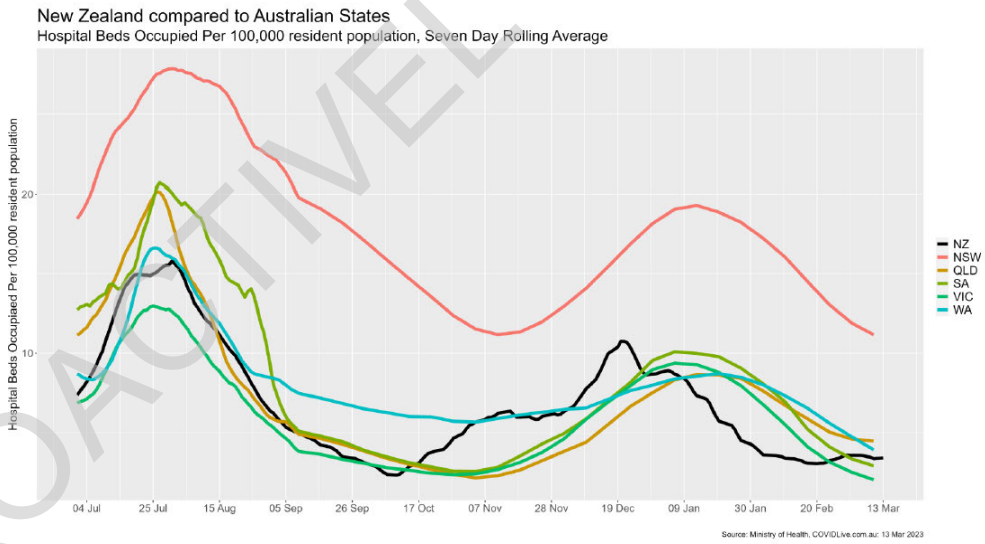
80. However, with that caveat, data on hospitalisations and deaths in Australia is likely to represent the most appropriate comparator for the New Zealand context. Australia and New Zealand both largely avoided significant levels of infection until Omicron, both had relatively well-vaccinated populations at that point, and the two countries have broadly similar population age structures. Hospitalisations and deaths are likely to be less affected by changes in reporting than case data.

81. Direct comparison of hospital bed occupancy for COVID-19 cases per capita in Australian states and New Zealand is provided in Figure 3 below. This comparison suggests the difference in isolation policy is not impacting on bed occupancy. However, caution must be taken in interpreting this data as the definition of what is recorded as a COVID-19 hospitalisation differs by jurisdiction:

a. New Zealand – cases are recorded for the full duration of their inpatient stay (from when they test positive)

b. Victoria – only counts COVID-19 hospital admissions if they are currently in hospital and testing positive (typically 5-7 days)

c. Other Australian states – some other states more completely match recorded cases with admissions data, and report as COVID-19 patients for a full 14 days regardless of whether the person is still testing positive.[11]



82. In addition, there are likely to have been changes during this period in terms of both administrative data collection and service provision. For example, 30 days after the Epidemic Notice expired in New Zealand, preliminary inspections performed under section 21A of the Coroners Act 2006 were no longer required to include the taking and testing of swabs in any case where the deceased is suspected to have had COVID-19 at the time of death.[12] In addition, in late 2022 some hospitals shifted from requiring RATs on admission to only testing where the patient had symptoms.

Case isolation is still considered to be an effective measure

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

a. A legal requirement to self-isolate remains a highly effective tool in 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.

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. Best practice approach to managing highly infectious notifiable diseases is for cases to isolate during their period of infectivity. This is the most effective tool for controlling disease transmission. The high transmissibility of COVID-19 reinforces the importance of case isolation.

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.

Changing the mandatory period of isolation has marginal benefits

84. *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 symptomatic cases to remain an effective intervention. A mandatory requirement for 5-day isolation would be less effective, as many people who are symptomatic may still be infectious to some degree on release at day 5.[13]

85. It is less clear for cases that remain asymptomatic as it is not known at time of positive test whether they are at the end of their infectious period or near the beginning. The WHO has recommended reducing the case isolation period to 5 days for cases who remain asymptomatic throughout the course of their infection.

86. Based on available information, most people who are symptomatic who are isolating are too sick to be able to work or go to school.

a. Based on data from healthcare workers in Canterbury, approximately 40% of cases were not well enough to return to work after completing 7 days isolation (noting that the survey was carried out earlier in the pandemic, and with the current outbreak context consisting of multiple waves and boosters, the duration of illness among healthcare workers may have decreased since).

b. Analysis of publicly available data from the Household Labour Force Survey (HLFS) undertaken by Statistics New Zealand has shown that there is a clear increase in the rates of being absent or working less due to sickness across 2022, ramping up towards Q2, and maintaining across the year. This coincides with large scale spread of COVID-19 in the community. The change is very clear when compared to rates prior to 2022, which were fairly consistent, with some seasonal fluctuations. While no causal inferences can

be analytically drawn from this data, this marked difference indicates that the usual causes of absence/working fewer hours likely cannot account for the observations in 2022. I also note that high rates of sickness absences continued despite the requirement for household contacts to self-isolate being removed in mid-2022. Subsequently, I am confident that participants did not interpret the survey question as including absences due to self-isolation requirements for contacts. Therefore, it is reasonable to conclude that illness caused by COVID-19 and associated case self-isolation requirements is having a sizable impact on the labour force, when comparing to the usual levels of sickness related reductions therein. The comparison to baseline (2017-2019) indicates up to an 80% increase in the level of absence/reduction in hours across Q2 – Q3 2022, and Q4 still sees an increase over 40% on baseline.

87. The HLFS does not allow us to determine the number of hours of workplace absence due to isolation requirements for COVID positive people who would otherwise have been able to return to work.

Removing case isolation and associated supports is likely to have a disproportionate impact on some population groups

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

a. Older people – the strongest risk factor for COVID-19 mortality is age.

b. Māori and Pacific peoples – a Manatū Hauora report on inequities in COVID-19 mortality found that Māori and Pacific peoples had more than twice the risk of death compared to European and Other groups.[14]

c. People living in deprived areas – 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. The Manatū Hauora report on inequities in COVID-19 mortality referred to above found that people from the most deprived communities were 3 times more likely to die from COVID-19 than those from the most affluent communities.[15] 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. 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. Disabled people – a recent report on the burden of COVID-19 on the disabled population found that this population group had significantly higher risk of severe outcomes than the general population.[16] People receiving Disability Support Services (approximately 43,000 people), were 9% less likely to be COVID-19 positive, but 4.2 times more likely to be admitted to hospital for COVID-19, and 13 times as likely to die due to COVID-19.

e. People with underlying health conditions – the Manatū Hauora report on inequities in COVID-19 mortality referred to above found that people with any comorbidities had more than 6 times the mortality risk of people without comorbidities.

89. See appendix 1 of the memo following 26 January 2023 PHRA meeting for more information on the rationale for continuing to require mandatory self-isolation for cases.

Appendix Two - Masks

Mask wearing is still an effective measure, but more flexibility is required

90. 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). Further healthcare settings are an especially vulnerable setting, and it is paramount that the public are safe to access healthcare with minimal risk of catching COVID-19, and have the confidence to access the healthcare they require.

The Mask Order has adverse effects for some people

91. The current Mask Order covers a broad range of environments such as health clinics, pharmacies, disability support services, and aged residential care homes, and masks are not always optimal for every setting. There is also a major difference in the length of time a person might be in a healthcare setting where the mask mandate is applied, ranging from a brief appointment to being full time resident.

92. This issue can arise for visitors to full-time residents in Aged Residential Care (ARC) facilities. For this group the health care setting is their home, and they often can have mobility issues which can make it difficult to leave the facility. The mask mandate means that all visitors to their home must wear face masks for the duration of the visit, unless an exception under section 6 of the Mask Order applies (such as they are eating or drinking, communicating with a person who is deaf or hard of hearing, or they have a physical or mental illness of condition or disability that makes wearing a mask unsuitable). There can be further complications depending on the health of the individual, such as residents with dementia finding masks disorientating, while for hard of hearing residents it is a barrier to communicate and can be very isolating.

93. While ARC stakeholders have indicated that they wish to enforce their own mask policies, comprehensive consultation of stakeholders from other affected healthcare settings on current mandatory mask requirements has not been completed.

The mandates are hard to enforce and compliance hard to measure

94. The Mask Order specifically excludes staff and patients in healthcare settings. This, along with the broad collection of services covered under the healthcare mandate, creates confusion to the public about when and where masks are required.

95. For example, the Mask Order applies to visitors to pharmacies, who are not there for healthcare reasons (e.g., not picking up a prescription or buying a health care product). Differentiating a 'visitor' from a 'patient' in these facilities is difficult and makes mask messaging and enforcement particularly challenging. Furthermore, it is difficult to know whether the actual benefit of the mask mandate is being realised in these settings when the mandate does not apply to all customers at any given time.

96. Currently there is very little public communications on mask requirement informing visitors that they are legally required to wear a mask and enforcement of the mandates is left to staff on the ground. This creates variability between sectors and facilities with how the mandate is interpreted and enforced.

Removing the Mask Order would allow facilities to develop appropriate mask settings

97. Removing the Mask Order does not need to be a pivot away from using masks as a measure, but instead allows each facility to develop appropriate settings. Currently healthcare providers are already responsible for the health and safety measures of staff, patients and visitors in all other areas of health and safety. Replacing the Mask Order with guidance would allow healthcare providers to make mask policies consistent across the facility and ensure the measures taken remain proportionate to the risks.

98. It is important to note, however, that not all sectors or persons conducting affected businesses or undertakings will have the capacity or capability to do this themselves. Te Whatu Ora emphasises that when schools were asked to undertake their own risk assessments in line with guidance, it placed on them a significant additional burden and in many instances resulted in schools opting for no mask requirements to avoid this burden and conflict with their communities. This highlights the need for national IPC mask guidance to be comprehensive and effectively communicated if mask requirements are removed.

99. As discussed, the enforcement of the Mask Order is left to each facility and often not implemented. Allowing healthcare providers to create setting appropriate restrictions would increase the likelihood the facility would also enforce them.

Appropriate IPC guidance will need to be prepared

100. There is currently IPC guidance for healthcare staff and patients provided by Te Whatu Ora[17] however this does not extend visitors to these facilities. Before removing the Mask Order, Te Whatu Ora and/or Manatū Hauora will need to provide clear and considered guidance on appropriate mask wearing procedures for each healthcare setting, noting that there is currently no national IPC technical advisory group or equivalent group that is well-placed to develop this guidance.

101. More developed guidance and communications would also enable more broad public messaging about the value of masks for high-risk settings, particularly when community transmission risk escalates.

Appendix Three – Point of Care Test Order

The self-isolation requirement no longer requires the POCT Order

102. The POCT Order has played a primary role in supporting the self-isolation requirement. It does this by ensuring the reliability of results produced by tests that legally require a COVID-19 case to self-isolate under the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022.

103. It is important that the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 is well supported because it imposes a significant limitation on a person's right

to freedom of movement. False-positive test results would mean the Government is imposing this rights-limiting measure on people unnecessarily.

104. The POCT Order is no longer justified is because it is no longer required to support the self-isolation requirement for COVID-19 cases. This is because:

a. there is currently a sufficient Government supply of approved RATs for the next 12 months

b. the public is not legally required to use Government funded tests

c. the private market is saturated with approved tests

105. Additionally, there are other mechanisms that ensure the quality of tests remain high.

106. Quality control of COVID-19 tests could continue through a procurement process instead of a separate regulation like the POCT Order (noting that there is currently no capability to proactively undertake this form of quality control).

107. New medical devices must be registered on Medsafe's Web-Assisted Notification of Devices (WAND) database within 30 days of being on the market. Medsafe can take post-market action to restrict sales of medical devices in Aotearoa New Zealand through WAND. While in vitro diagnostic devices such as COVID-19 RATs are currently exempt from this requirement, if the POCT Order is revoked this could be changed to provide further assurance that quality of tests sold in Aotearoa New Zealand remains high.

108. If the POCT Order is revoked and the options for increased quality assurance noted in paragraphs 10-11 are not implemented, then the quality of tests distributed and used in New Zealand remains assured under the Consumer Guarantees Act 1993, the Fair Trading Act 1986, and the Health and Disability Commissioner Act 1994.

Implications for current Government-funded tests

109. There are no risks with current products assessed and approved via the point of care exemptions process or with current Government supply of tests.

110. However, approved products require continued monitoring of expiry dates and efficacy of products to detect new variants as there is currently no process for post-market assessment or revisitation for in vitro products.

111. Revoking the POCT Order would mean that an internal validation process would be needed when purchasing new Government test supplies.

s 9(2)(h) [redacted]

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

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

Implications of allowing a private market for tests

114. Removing the POCT Order would open up the private market for tests as it currently stands for other in vitro testing products. This risks some poor-quality products being imported into Aotearoa New Zealand, which may lead to a small increase in false-positive and false-negative test results.

115. False-negative test results cause people to falsely believe that they do not have COVID-19, which poses health risks for the individual themselves and the risk of behaviour that further spreads the virus.

116. False-positive test results cause people to self-isolate unnecessarily, which can cause social and financial hardship.

Equity considerations

117. If cheaper, less effective products are available on the private market, then it would disadvantage those who a more deprived. This is because they would need to either:

a. spend their limited money on expensive tests that provide more reliable results, or

b. choose not to test and risk suffering health impacts from being unaware they have COVID-19 or spreading the virus to their whānau, or

c. purchase cheaper, less effective tests, and subsequently risk suffering poorer health and hardship, from which they already disproportionately suffer in virtue of being highly deprived.

118. This equity risk can be mitigated by ensuring that free RATs and PCR testing remain available and accessible for priority populations.

Endnotes

[1] COVID-19 Modelling Aotearoa, ordinary differential equation model, December 2022
[2] https://www.esr.cri.nz/assets/HEALTH-CONTENT/COVID-Genomics-Insights-Dashboard-CGID/CGID_35_Report.pdf
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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:	31 March 2023

Problem Definition

Under the New Zealand 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 review of current settings under the legal framework for managing the COVID-19 pandemic. Specific requirements are set out in the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 (the Self-isolation Order), the COVID-19 Public Health Response (Masks) Order 2022 (the Masks Order), and the COVID-19 Public Health Response (Point-of-care-Tests) Order 2021 (the Point-of-Care Tests Order) all of which are made under the COVID-19 Act. The RIS provides information and analysis on the recommendations to:

- Retain the Self-isolation Order
- Revoke the Masks Order
- Revoke the Point-of-care Tests Order.

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 (IPC) measures.

The Masks Order establishes the requirement that people visiting healthcare services wear face masks. It is important to note that the Masks Order excludes patients and staff.

The RIS draws on analysis including:

- information from the Public Health Risk Assessment (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.

Self-isolation of cases

The PHRA recommended that mandatory 7-day 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, the PHRA assessed that this measure is more effective than other less restrictive measures, or a combination of less restrictive measures, such as face masks or physical distancing.

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 peoples, 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 on public transport) have been removed in New Zealand suggests that adherence to guidance is typically much lower than to mandates.

Equity and Te Tiriti o Waitangi analysis support retaining mandatory self-isolation for cases. Health impacts 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.

Masks

The PHRA recommends that the Masks Order be removed and be replaced by national IPC guidance supporting bespoke policies in each setting**.** The current Masks Order covers a broad range of environments such as health clinics, pharmacies, disability support services, and aged residential care homes. However, masks are not always optimal for every setting. Removing the Masks Order will enable providers to create bespoke policies to best cater to their respective communities and the community risk at the time.

Further, the Masks Order only applies to visitors which can create confusion about who needs to wear masks and where. Allowing providers to develop policies for everyone on their premises will enable them to produce consistent mask requirements, in context of their wider IPC measures, and communicate these effectively.

Healthcare services includes 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 healthcare settings remains a crucial measure and there is a need for up to date and clear guidance on mask use.

Point-of-care tests

The context of the pandemic has changed significantly since the introduction of the Point-of-care Tests Order. False positive and negative test results no longer pose a significant risk, given the current level of community transmission.

The quality control of COVID-19 testing products can be carried out via a procurement process, rather than a separate regulation such as the Order, and through other existing regulatory mechanisms such as the Consumer Guarantees Act 1993. Further, the currently

regulated point-of-care testing are free and available. Consequently, the Point-of-care Tests Order is no longer proportionate to the risk.

Implementation, monitoring, and review

The settings recommended for self-isolation are already in place and would require no additional implementation.

The removal of the Masks Order would require updated IPC guidance to include visitors to healthcare facilities.

The removal of the Point-of-care Tests Order will enable existing regulatory mechanisms to apply to these devices.

These measures remain under regular monitoring and review, including through regular PHRAs.

Limitations and Constraints on Analysis

This proposal is subject to the following limitations:

- limited time to prepare this RIS
- 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. 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.

While these limitations are acknowledged, 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

29 March 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

New Zealand currently has a set of public health measures – both mandatory and non-mandatory – form a pragmatic approach to managing COVID-19 which includes:

- **case isolation** - requiring cases to isolate for 7 days.
- **vaccination** - 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 community immunity. Uptake of the first booster is stable at 71.5%, and uptake of the second booster uptake has risen slightly to 49% of the eligible population. The bivalent booster become available to eligible members of priority groups from 1 March 2023 to those aged 30 years and over on 1 April. The bivalent booster provides targeted protection against Omicron subvariants.
- **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.
- **access to antivirals for population groups at higher risk of severe disease** - antivirals reduce this risk but need to be taken within 5 days of a person becoming symptomatic to be effective. In the age bracket 50-64 years, antivirals have been provided to 51% of Māori cases and 50% of Pacific Peoples cases. This has been achieved through comprehensive support provided by Māori/Pacific coordination hubs.
- **testing** - encouraging household contacts to test for 5 days following the initial case in their household, and testing for anyone who is symptomatic, supported through the distribution and supply of free rapid antigen tests (RATs).
- **masks** - 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.
- **tailored communications** - across channels and communities to support and reinforce good public health behaviours.
- **surveillance of COVID-19** - including whole genome sequencing to identify new subvariants and wastewater testing to track trends over time.

Under the New Zealand Bill of Rights Act 1990 and the COVID-19 Public Health Response Act 2020, the Government has a responsibility to ensure its response to COVID-19 remains effective, justified, and proportionate, while avoiding, mitigating, or remedying the actual or potential adverse effects of the COVID-19 outbreak. Due to the use of emergency measures, they must be regularly reviewed.

A Public Health Risk Assessment (PHRA) carried out on 16 March 2023 considered whether any changes are required to current COVID-19 public health settings. The measures in question are established by the Self-isolation Order, the Masks Order, and the Point-of-care Tests Order.

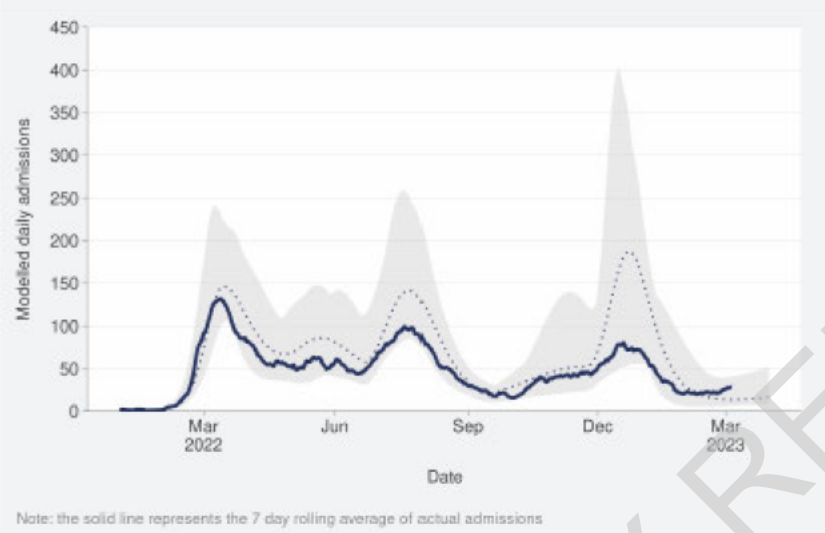
The PHRA was based on recent data about the progress of the pandemic, modelling of likely future developments, and on input from community sources.

How is the status quo expected to develop?

Overall, the key measures of infection (levels of viral RNA in wastewater and reported case rates) used to monitor COVID-19 remain stable compared to the last PHRA in January 2023 in most regions after increasing slightly towards the end of February 2023.

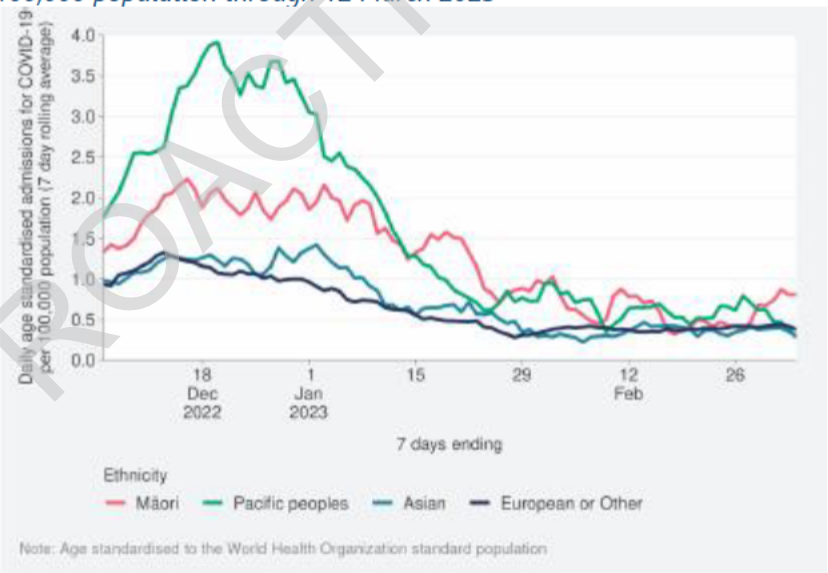
COVID-19 related hospital admission rates have increased in the week ending 5 March 2023, following the recent slow increase in cases in late February 2023, and are tracking in the upper bound of the 95% confidence interval (figure 1). Hospitalisations that are classified as being 'for COVID-19' are higher than the incidental rate[1]. Since October 2022, COVID-19 related hospital admissions of patients admitted for COVID-19 related illness were 1.8 times higher rather than those admitted who incidentally had COVID-19.

Figure 1 - COVID-19 hospitalisation Modelling Aotearoa scenarios compared with national through 12 March 2023[i]



There are differences in the rates of hospitalisation by ethnic group. The age standardised rate continues to show that Pacific peoples and Māori have had the highest risks of hospitalisation for COVID-19 – 2.3 and 1.8 times the risk of European or Other, respectively. In the week ending 5 March 2023, Māori had the highest age adjusted admission rate (0.9 per 100,000).

Figure 2 – Modelling Aotearoa COVID-19 daily age standardised hospital admissions for COVID-19 per 100,000 population through 12 March 2023



Further, a review of people with disabilities' experience of COVID-19[2] found that Disability

[1] Incidental rate reefers to cases in hospital for non-COVID-19 related reasons for also happen to have COVID-19 as opposed to individuals in hospital because of COVID-19

[2] https://www.health.govt.nz/publication/covid-19-risk-among-disabled-people

Support Services (DSS) recipients have had four times the risk of hospitalisation when compared to the rest of the population during 1 January - 16 November 2022. Analysis undertaken by Whaikaha found that DSS recipients who receive residential support are 8 times more likely to be hospitalised.

What is the policy problem or opportunity?

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

In February 2023, Cabinet agreed to retain mandated 7-day isolation for cases and mask requirements for visitors to healthcare services. This decision was made in the context of uncertainty of case numbers coming out of summer and the concern of how removing measures would exacerbate inequities.

As noted above, while the situation has stabilised, we are still seeing significant inequities in those most at risk to COVID-19. While we are currently seeing a stabilisation in cases, hospitalisations, and deaths it is hard to know how long this will last.

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 minimises 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 three remaining mandatory measures that are under consideration:

- self-isolation of cases
- masks by visitors in healthcare settings.
- restrictions on point-of-care tests

Based on preliminary analysis, the practical choices arising out of the 16 March 2023 PHRA have been narrowed down to the following:

Self-Isolation

- Retain the status quo of mandatory 7-day isolation for cases
  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 Masks Order requiring people visiting healthcare services wear face masks.

Point of Care Tests

- Retain the Point-of-care Tests Order restricting the importation of point-of-care testing unless the provider has an exemption from Te Whatu Ora
  or
- Remove the Point-of-care Tests Order restricting the importation of point-of-care testing unless the provider has an exemption from Te Whatu Ora.

Discussion - mandatory self-isolation for cases

Self-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 self-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 self-isolate results in significantly greater adherence than a recommendation to self-isolate. Experience when other mandates 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

Mask mandates have been an important measure in ensuring high up take of masks in healthcare settings which cater to an especially vulnerable population. Further, the mandates have served to protect the health workforce who underpin the system's ability to respond to the COVID-19 outbreak. However, with case numbers being consistent over the past three months, and reports from the sector that mandates are becoming harder to enforce, it raises the question of whether an emergency Order is still required.

Removing the Masks Order would also allow health settings to form their own health and safety policies for mitigating the spread of COVID-19. This would enable healthcare providers to use their experience gained over the past three years of managing COVID-19 to best meet the needs of the community they are serving through IPC measures that are proportional to the COVID-19 risk/situation at any given time. Healthcare providers are experienced in mitigating the spread of infectious diseases.

Healthcare providers are also already responsible for the health and safety measures of staff, patients, and visitors in all other areas of health and safety. Removing the Masks Order would allow healthcare providers to make mask policies consistent across their facilities and ensure IPC measures remain proportionate to the risks.

Crucially, mitigation measures for COVID-19 will differ greatly from setting to setting and at different points in time. A bone marrow transplant unit will require different IPC precautions to ARC facilities which would be different again to allied health facilities. The current mask mandate holds all healthcare settings to the same requirement regardless of the risk profile, the type of facility, or needs of the community.

Discussion – Restriction of point-of-care tests

Point-of-care testing refers to tests which do not require a lab to process and instead provide a test result at the point of care. In relation to COVID-19 this Order primarily deals with the supply of RATs though covers any other point-of-care COVID-19 test.

The Point-of-care Tests Order was initially put in place when New Zealand was pursuing an elimination strategy, and it was vital that any case was accurately identified. As a result, the quality and reliability of tests was considered paramount so, uniquely amongst medical devices in New Zealand, the supply and use of point-of-care testing was regulated. New Zealand has shifted away from the elimination strategy and our approach to managing COVID-19 has evolved. Notably, the COVID-19 Act was amended to narrow the scope of powers available to implement public health measures to support the COVID-19 Response.

After the 26 January 2023 PHRA, the committee commissioned a point-of-care testing review meeting to investigate if the Order was still proportionate and necessary given:

- the stabilising case numbers
- the Government being the primary distributor of RATs
- the Government's ability to quality control by being the largest purchaser

The review concluded that there was no longer a public health justification to treat point-of-care testing differently to any other testing devices which Medsafe does not and are instead subject to The Consumer Guarantees Act 1993.

Removing the Point-of-care Tests Order could increase access and affordability for communities who are currently purchasing their RATs (as opposed to receiving free packs from the Government).

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.

Proposal to retain self-isolation

- There was generally strong support from population agencies, and agencies with a State duty of Care for the proposal to retain the requirement that cases self-isolate for 7 days. Many commented on the purpose of this requirement being to protect those most vulnerable, and also to reduce transmission so as to impact the health and/or economic impacts of COVID-19.
- Two sector-based agencies commented that the current requirement was challenging. The Ministry of Transport referred to correspondence from the aviation sector regarding the impact they felt the requirement was having on their business, and supported a reduction to 5 days isolation (not one of the options considered). MBIE Tourism commented on the impacts on tourists and potential impacts on the tourism sector.

Proposal to remove the requirement that visitors wear masks in health service settings

- Most population agencies explicitly opposed this proposal. They noted that the requirement helped to keep people at higher risk of severe outcomes safer, and that vulnerable people are often not able to avoid going to health service settings (including aged and disability residential care).
- Other agencies tended not to express a view.

Proposal to remove regulation regarding COVID-19 point-of-care tests

- Te Whatu Ora was the only agency to provide substantive feedback on this proposal. This feedback indicated that 4 weeks' lead time would be required.

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

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.

COVID-19 continues to have disproportionate impacts on certain population groups. These impacts include:

- **Socioeconomic status** - there is also an acknowledged differential exposure to COVID-19 risk related to socioeconomic status.
- **Māori and Pacific People** - the cumulative total age-standardised hospitalisation rate to 12 March 2023 shows that Pacific peoples and Māori have had the highest risks of hospitalisation for COVID-19: 2.3 and 1.8 times the risk of European or Other, respectively. Reinfections account for approximately 12% of recently reported cases for Pacific Peoples, and 11% of recently reported cases for Māori.
- **Disabled people** - a recent review found that DSS recipients have had 4.2 times the risk of hospitalisation when compared to the rest of the population during 1 January – 16 November 2022, and were 13 times more likely to die due to COVID-19. Further analysis undertaken by Whaikaha found that DSS recipients who receive residential support are 8 times more likely to be hospitalised than the general population.
- **Older people** - are more likely to have severe illness than younger people. People aged 50 years and above have accounted for 650,865 cases (29% of total cases), of whom 2,547 have died (98% of total deaths) in the period to 20 March 2023.
- **Young adults** - the proportion of cases that are reinfections has increased steadily since late 2022. Based on cases reported between 1-23 March 2023, reinfections account for 41% of reported cases overall, and 59% of cases reported for people aged 20-29 years.

Other population and sector impacts include:

Proposal to retain self-isolation

- **Te Aka Whai Ora** supports the retention of mandatory case isolation, and notes that 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 who are more likely to be in precarious employment, with less access (or no access) to paid sick leave, or where there is a greater power imbalance with their employer.

- **Te Puni Kokiri** supports the retention of the 7-day isolation period to ensure that whānau with COVID-19 can fully recover from the ailment. Also, the isolation period is a safe measure in ensuring that community cases are low. If the isolation period is reduced or removed, this could have a big impact on small-medium enterprises – including Māori SMEs. It is also possible that a reduction in the isolation period could pressure infected people into returning to work/school before they are fully recovered – this could lead onto an increase in community cases.

- **Te Arawhiti** supports the retention of case isolation and notes that 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. Given the negative impacts that repeat infections may have on immune systems, the need for case isolation requirements is heightened.

- **The Ministry for Pacific Peoples** notes that Pacific peoples are more vulnerable to COVID-19 risk-factors, and anticipates that Pacific peoples will continue to experience a greater burden from the ongoing health and economic consequences of COVID-19. Given the risk factors that Pacific peoples are subject to, and the burden that COVID-19 has had on Pacific peoples to date, the Ministry supports options that best protect the health and wellbeing of Pacific peoples, whilst balancing other economic and social considerations.

- **Whaikaha** supports the retention of mandatory case isolation, and notes that COVID-19 has exposed the existing inequities that disabled people face in their everyday lives, and many existing inequities for disabled people and their whānau have been exacerbated. Disabled people experience particular risks associated with co-morbidity of health conditions. Given international and domestic evidence shows disabled people experience disproportionately high mortality and infection rates, some disabled people report that they continue to be fearful of leaving their homes, even for essential services. The lack of feeling safe is as relevant as being safe and will impact behaviours. Ensuring mandatory self-isolation of 7 days for positive cases will help mitigate against further impacts on community participation.

- **Oranga Tamariki** supports the retention of mandatory case isolation as a key protective mechanism, particularly for vulnerable communities.

- The **Tourism group from the Ministry of Business, Innovation, and Employment (MBIE)** does not have a preferred option, but notes that the self-isolation requirement can be problematic for international visitors. Over time this is likely to increase the attractiveness of other destinations that don't have these requirements relative to New Zealand which will have an economic impact (it is very hard to estimate this given all the other disruptions/factors influencing international travel). The MBIE Tourism team also notes that the FIFA Woman's World Cup will be held in NZ and Australia in July/August, and forecast visitor numbers will mean that this is a much busier winter than usual. The high profile nature of this event may mean that more public attention is given to this issue.

- The **Ministry of Transport (MoT)** notes similar concerns in relation to the FIFA Women's World Cup. In addition, MoT notes that case isolation requirements are impacting on existing workforce shortages across the aviation sector which are already under significant pressure. The aviation sector would support a reduction in the period of mandatory isolation to 5-days, 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.

Proposal to remove the requirement that visitors wear masks in health service settings

Most population agencies explicitly opposed the removal of the visitor mask mandate from health service settings.

- **Te Aka Whai Ora** does not support the removal of mandatory face mask requirements, due to the potential for adverse impacts this would have on Māori who already suffer disproportionate health outcomes.

- Te Aka Whai Ora noted that there is currently insufficient information available to properly assess the likely impact of changes to public health restrictions, such as mask requirements in healthcare settings. It is not sufficient for the Crown to rely on whole-of-population data or modelling to determine the appropriateness of changes to public health restrictions that may have a disproportionate impact on Māori. Without an appropriately thorough evidence base about the impact of policy settings on Māori, it is not possible to make an assessment of the effectiveness of those settings (such as a mask mandate) or the impact on Māori if they were to be changed.
- For this reason, Te Aka Whai Ora recommends making no changes to public health restrictions until a more thorough assessment can be undertaken. Te Aka Whai Ora considers that, in the absence of an adequate analysis of the impact of potential changes to public health restrictions on Māori, it is not appropriate for the Government to make a decision to change the existing restrictions around the use of masks in healthcare settings or self-isolation of COVID-19 cases.
- Te Aka Whai Ora notes that COVID-19 remains a significant issue for Māori, accounting for 4% of all Māori deaths in New Zealand in 2022.[3] Māori (and Pacific) peoples have more than twice the risk of death from COVID-19 compared to European and Other groups.[4]

- **Te Puni Kokiri** does not support the removal of the Masks Order for visitors to health service settings. Aligned with the concerns and issues identified by Te Aka Whai Ora, Te Puni Kokiri believes that this could have negative impacts on vulnerable communities, immune compromised whānau, and Māori who are overrepresented in negative health statistics. Te Puni Kokiri supports the recommendation made by Te Aka Whai Ora that no changes should be made within this area until a thorough assessment has been conducted.

- **Te Arawhiti** does not support the removal of mask requirements for visitors in health service settings, and would instead support expansion of mask wearing requirements to public transport.

- **Whaikaha** does not support removal of the Masks Order noting that even with the current mandatory settings in place, DSS recipients who receive residential support are 19% more likely to report a positive COVID-19 test result, 8 times more likely to be hospitalised and 47 times more likely to die with or of COVID-19. Whaikaha has also noted that any change in these data that might arise from adopting a policy-based approach to visitor mask use has not been quantified. Whaikaha recommends that decisions to remove mandatory face mask requirements are not made until such a time that regular data is collected on DSS recipients' COVID-19 outcomes.

- The **Ministry for Ethnic Communities** notes that continuation of the status quo may give some reassurances to some ethnic communities who are vulnerable to COVID-19 such as the elderly and those with an underlying health condition(s).

- **Oranga Tamariki** notes many of the concerns raised by other population agencies above. In addition, Oranga Tamariki also noted potentially reduced protection for children and young people (particularly those more vulnerable due to being unvaccinated), increased tension and confusion for caregivers/parents/guardians

[3] This is based on a comparison of Māori deaths reported by Stats NZ in *Monthly death registrations by ethnicity, age, and sex: January 2010 to December 2022*, and Māori deaths reported in 2022 by Manatū Hauora as attributable to COVID-19.

[4] https://www.health.govt.nz/publication/covid-19-mortality-aotearoa-new-zealand-inequities-risk

around using masks in healthcare settings (e.g. differing opinions between caregivers and parents). Oranga Tamariki notes that removal of this measure may increase the risk of children and young people spreading COVID-19 to more vulnerable people in their communities.

- Oranga Tamariki also notes that if this measure was removed, they would support the proposed mitigation – i.e. "clear guidance for health service providers". However, Oranga Tamariki suggested this is expanded on if possible to give further assurance – e.g. in line with Te Whatu Ora feedback (paragraph 92) which states that the guidance should include "a national document that provides key guiding principles and considerations to enable facilities /policy makers or specialist groups responsible… to enable national consistency, but some flexibility given the different services, risks and needs within facilities that provide healthcare"
- The **Ministry of Social Development** advised against removing the requirement of masks for disability and health services, given the number of people in these spaces that may be more vulnerable to COVID-19.

Please see Appendices 2, 3 and 4 for full feedback from agencies.

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

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

s 9(2)(h) [redacted]

s 9(2)(h) [redacted]

s 9(2)(h) [redacted]

s 9(2)(h) [redacted]

s 9(2)(h) [redacted]

s 9(2)(h) [redacted]

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 (where relevant).

These criteria are aligned to the criteria for the new strategic approach. 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 self-isolation requirement

Counter-factual and proposal

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

Public Health Risk Assessment

PHRA recommendation	Maintain the current requirement that cases self-isolate for 7 days. 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
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	+/- • 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 the Government in response to the current pandemic. While there are other measures, no less restrictive measure is as effective at slowing the spread of COVID-19 This	- • This approach is likely to lead to significantly higher numbers of cases, hospitalisations, and deaths. • Modelling carried out in March 2023 estimated that removal of mandatory self-isolation could increase case transmission by as much as 15%. This would result in an expected 88% increase in hospital bed occupancy in the 26 weeks following the changes.

	overall approach is considered a proportionate response to the COVID-19 pandemic, although restrictions of BORA rights are involved.	
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 the COVID-19 Protection Framework (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 critical services, and on wider society. It's important to note that these impacts will decrease as overall case numbers decrease.	+ • Removing mandatory case self-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). Shortening or removing the self-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 due to 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.
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.

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, particularly for vulnerable communities.

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	Revoke the current face mask mandate in health service settings, with Te Whatu Ora to implement national IPC guidance, before the Order is revoked, to support stakeholders to manage risk levels on their premises To move away from broad health sector wide emergency measures will move some of the responsibility back to health care providers. This enables providers to create bespoke policies to best cater to their respective communities and the community risk at the time. It also allows for consistent mask polices across patients, staff, and visitors.

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. We have seen when mask mandates have been removed in other settings adherence drops. • Throughout the pandemic hospital-acquired COVID-19 infections are more likely to have poorer health outcomes than community-acquired infections. • Individuals often do not have a choice in whether they need to access a health service.	++ • It is unclear how big a drop off in compliance there will be once the mandate has been removed. • Clear guidance and an involved sector could potentially lead to as good or better outcomes without the need of the emergency measure. • Healthcare providers are already trusted to set a range of health and safety measures in their facilities, this includes mask usage of staff and patients. • Government guidance could be issues to further equip healthcare settings to keep good mask practise.
Economic and social impact - evidence of the effects of the measures on the economy and society more broadly	+/- • Keeping transmission of COVID-19 low in health services is important to keep 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.	- • Masks can be uncomfortable and can create barriers to communicate and support patients in healthcare settings. • 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. • Supports elderly and disabled communities who live in health care settings to connect with friends and whānau. Currently these groups can only see visitors who are masked which can be isolating. • Supports disabled communities such as the deaf community who find masks an obstacle to communicate.
Compliance - expected public compliance with measures	+/- • Adherence to face mask requirements appears to be waning in some health service settings, the more normalised COVID-19 is in the community the less measures are followed, even when required.	+ • Currently there is very little public communications on mask requirements informing visitors that they are legally required to wear a mask. Enforcement of the mandate is left to staff on the ground. • This creates variability between sectors and facilities with how the mandate is interpreted and enforced. • Letting the facilities who enforce mask compliance set the guidance may see better enforcement in high-risk settings.
Overall	+/- • The Masks Order is no longer proportionate to the public health risk. Healthcare providers are entrusted to set their own health and safety standards for a range of other settings and are capable to do so here without the use of the Order.	+ • Given the stage of the pandemic, and the ability for healthcare providers to create their own settings (as they do for staff and patients) guidance would be a suitable alternative. This emergency measure is no longer justifiable and proportionate at this time.

3. Point of Care testing Order

Option 1	Option 2
Status Quo: The Point-of-care Tests Order requires Te Whatu Ora to approve the importation and supply of various point-of-care test (including RATs) in order to be available in New Zealand.	Removal of the Point-of-care Tests Order and allow open sale of point-of-care tests on the market.

Public Health Risk Assessment recommendation

PHRA recommendation
To revoke the Point-of-care Tests Order which is currently regulated under the COVID-19 Act that restricts the importation and supply of point-of-care tests (including RATs). The Point-of-care Tests Order is no longer required as there is no public health justification to treat point-of-care tests differently from any similar testing devices. Point-of-care tests are currently the only medical device that has regulation in place.

Multi-criteria assessment

Criteria	**Option 1: Status quo –** **Point-of-care Tests Order remains in place**	**Option 2:** **Remove the Point-of-care Tests Order**

Proportionality as required in the COVID-19 Act - the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds BORA considerations	+/- • The Order restricting the importation and supply of point-of-care tests ensures a high standard of tests is distributed.	+ • Mandatory self-isolation is not dependant on the Point-of-care Tests Order and if this self-isolation was to remain, it is still not legally proportionate to continue while the Government is providing RATs for free to the public. • With clear guidance and other forms of regulatory mechanisms for importing of point-of-care testing, could potentially lead to good or better outcomes without the need of this order.
Economic and social impact - evidence of the effects of the measures on the economy and society more broadly	+/- • Keeps private market in place so a controlled standard of test is on the market.	+ • Removing the Order would open up the private market as per other testing products, which will increase the risk of some poor-quality products being imported leading to an increase in false positives and negatives (inaccurate diagnosis). • It will open the market up and allow for a wider range of products. • More products will generate a more competitive market, making RATs cheaper and more accessible for those who purchase them.
Equity - Evidence of the impacts of the measures for at risk populations	+/- • Reliable and accurate tests would continue to be readily available and accessible for free, will not disadvantage due to being accessible. • No shortage of tests – currently sufficient supply of RATs for the next 12 months.	+/- • Opening of the market to all tests raises an equity risk. If cheaper and less effective products are available on the market, those who cannot afford more expensive tests could be disadvantaged.

		• Removing the restrictions would increase affordability and access for communities who are currently purchasing their RATs. • Access issues can be mitigated by continuing to have free RATs and PCR testing for priority populations.
Compliance - expected public compliance with measures	+/- • With the Point-of-care Tests Order in place, the Government is legally required to administer applications despite the sufficient supply of RATs.	+/- • Instead of a separate regulation, quality control of COVID-19 testing products can be done through a procurement process which can include a post market review of ongoing effectiveness with new variants. • Other regulatory mechanisms exist to ensure the product quality is at a high standard i.e. The Consumer Guarantees Act 1993 (CGA).
Overall	• Given the current COVID-19 context and potential public health impacts, the Point-of-care Tests Order is no longer proportionate to restrict access to RATs.	++ • There is no public health justification for continuing with this Order and to treat point-of-care testing differently to any other similar testing devices.

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 for 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).

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 Whānau 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 4.2 times higher than the general population. Further, rates of COVID-19 attributed mortality are approximately 13 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. It is important that if the Masks Order is removed suitable guidance and communications is produced to reassure this community and keep mask use high.

Equity analysis for other/all groups

The most deprived populations continue to have the highest rates of hospitalisation, and have nearly 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.

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.

The removal of the Masks Order could create additional risk for vulnerable groups. Healthcare settings cater to vulnerable populations and any stepping down of masks increases the risk of COVID in these settings.

Conversely in aged residential care and disabled care homes removing the Masks Order will enable elderly and disabled living in healthcare facilities to have more control over the settings they live in and how they engage with visiting friends and whānau.

The removal of the Point-of-care Tests Order has limited impacts on equity groups as the government currently administers free RATs. The removal of the Order could generate better competition in the private market, increasing availability and lowering the cost on communities purchasing their own tests.

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 Chairs 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) Remove mandatory face masks for visitors to healthcare services
c) Remove the Point-of-care Tests Order

Section 3: Delivering an option

How will the new arrangements be implemented?

The settings recommended for self-isolation are already in place and would require no additional implementation.

The removal of the Masks Order would require updated IPC guidance to include visitors to healthcare facilities. Manatū Hauora will work with Te Whatu Ora on developing and decimating appropriate guidance.

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 May 2023.

Appendix 1: Case isolation – impacts on populations and operations

Population and sector impacts

Agency	How the proposal may affect this group
Office for Seniors, MSD	The Office has no particular comment on Case Isolation and Point of Care Test decisions. However, we have some concerns about the removal of a mask mandate for visitors to health service settings, especially aged residential care. Given the timeframe, we suggest addition of the following commentary to the first table in Appendix 3, under the population group title "Older People": Older people are at heightened risk of adverse impacts resulting from COVID-19 infection, especially those with additional overlapping vulnerabilities such as other health conditions. A reduction in mask-wearing by visitors to health settings could result from removal of these restrictions (although we acknowledge that facility-specific measures could compensate). There is insufficient evidence presented to determine the risk of infection and adverse reactions among older people as a result of this change, although we accept it is likely to be small. However, for some older people there is likely to be a heightening of concern about COVID-19 infection for older people in places they are living (for those in aged residential care) or visiting for necessary medical treatment. These concerns are justifiable in light of the significantly greater risks that COVID-19 infection poses to older people, as well as instances of COVID-19 spreading through aged care and similar facilities in New Zealand and overseas during the earlier stages of the pandemic. If a decision is made to remove the mask mandate investment should be made in public health messaging recommending mask wearing in certain circumstances and promulgating advice to the likes of aged care providers on how to reduce the risk of the spread of infections such as COVID, influenza and colds. The appropriate place of mask-wearing within public health measures needs to be normalised in such settings.
Disabled people including tāngata whaikaha Māori	COVID-19 has exposed the existing inequities that disabled people face in their everyday lives. About 24% of the New Zealand population identified as being disabled in the 2013 Disability Survey. As disability is not recorded on a person's NHI number, where most COVID-19 data and insights are obtained, it has been difficult to gain a full picture of the impact of COVID-19 on all disabled people. However, we know that disabled people experience particular risks associated with co-morbidity of health conditions. Disability Support Service (DSS) recipients are likely to have more complex needs, a medical condition which puts them at greater risks, live with other people, and receive support that requires close contact with other people.

	One-off analysis undertaken by Manatū Hauora and Whaikaha showed that people receiving DSS have been at greater risk of severe outcomes (hospitalisation and death) due to COVID-19, over the period 1 January – 16 November 2022. These risks are significantly greater for people who receive residential support. Whaikaha's view is that a step-down in the current measures will place disproportionate impacts on disabled people and their whānau to keep themselves safe. This may mean that more disabled people and their whānau withdraw from participating in their communities. While a decision to move to 5-day isolation may have positive impacts on the disability support service workforce, these benefits would be outweighed by the overall COVID-19 risk. To ensure disabled people and their whānau have the confidence to participate in their communities, we recommend the following steps are taken before a decision is made to step-down from the remaining protective measures: • Consultation with the disability community, in line with the UN Committee on the Rights of Persons with Disabilities' 2022 recommendation 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". • A commitment to regularly collect, monitor and model case rates, hospitalisation rates, and mortality rates for DSS clients. Complementary to these steps, Whaikaha encourages: • Disaggregated data collection on antiviral and vaccination uptake, and the prevalence of Long COVID-19 . • A public awareness campaign targeted at encouraging positive COVID-19 behaviours (masking, social distancing) to protect at-risk population groups, including disabled people. • Greater support for the vaccination workforce to ensure COVID-19 vaccinations are accessible and responsive to the needs of the disability community. The Immunisation Advisory Centre (IMAC) on line course is available to assist vaccinators with supported decision making and the application of the informed consent process. Encouraging vaccinators to complete this course will ensure the rights of disabled people are upheld during COVID-19 vaccination. If a decision is made to amend the current settings, Whaikaha would recommend that: • Decisions are communicated in accessible formats, at the same time as communications to non-disabled people. • Minimum ventilation standards are established and communicated to people, to enable informed choice and control over COVID-19 exposure risks. • Masks and COVID-19 tests remain free and easily accessible so that those who require and still want to use them.
Māori	***Te Puni Kōkiri***

	We support the retention of the 7-day isolation period to ensure that whānau with COVID-19 can fully recover from the ailment. Also, the isolation period is a safe measure in ensuring that community cases are low. If the isolation period is reduced or removed, this could have a big impact on small-medium enterprises – including Māori SMEs. It is also possible that a reduction in the isolation period could pressure infected people into returning to work/school before they are fully recovered – this could lead onto an increase in community cases. Aotearoa continues to be in a fragile economic state, vulnerable to a slowing world economy and the high dependence on imports. The impact of COVID and the measures currently in place are not likely to contribute significantly to that situation. However recent flooding across northern NZ could increase vulnerable populations susceptibility to infection due to emergency accommodation and whānau providing shelter to neighbours and whānau. Given the increase in variations internationally and the disturbance in Auckland and other parts of the North, we would recommend that a status quo approach be taken over the next few weeks to ensure any new and more virulent strand can be isolated quickly. The removal of mandatory isolation at this time is not preferred, as this would also impact the availability of support that whānau may need to stay home if positive. 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 covid positive cases out in the community. There would be concerns with removing the requirements to self-isolate for Māori Business – as we saw in previous waves, 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 I assume is the natural consequence of removing mandatory isolation. Public health should increase testing and vigilance in those disrupted communities and provide accommodation to those with COVID to mitigate the risks. It should also 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. ***Te Arawhiti*** We support the retention of current case isolation requirements and note previous PHRA's which have advised that anything less than a seven-day isolation period would likely render the mechanism ineffective. 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. Given the negative impacts that repeat infections may have on immune systems, the need for case isolation requirements is heightened. We are conscious 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 for Māori would be exacerbated, 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. Moreover, we are hesitant about 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. With the revocation of the Order regulating the supply of RATs into the country, our only other feedback on the paper, is to emphasise the need for RATs to remain free and easily accessible to help with the identification of infections.
Pacific peoples	***The impacts of the measures on economically vulnerable people?*** • Pacific peoples are more vulnerable to COVID-19 risk-factors, and we anticipate that Pacific peoples will continue to experience a greater burden from the ongoing health and economic consequences of COVID-19. Because Pacific people are more at-risk for severe COVID-19 infection including hospitalisation, ICU care and death, they may continue to require more intensive support, monitoring and follow up for COVID-19 related illness. • Given the risk factors that Pacific peoples are subject to, and the burden that COVID-19 has had on Pacific peoples to date, the Ministry supports options that best protect the health and wellbeing of Pacific peoples, whilst balancing other economic and social considerations. We maintain that the public health considerations for Pacific peoples are paramount, given the risk-factors Pacific peoples are vulnerable to, our lower rates of the booster and paediatric vaccinations and proportionately high levels of hospitalisations and deaths. • Because the COVID-19 Leave Support Scheme is still operational, we anticipate the economic impacts of having to isolate with COVID-19 to be minimal and be outweighed by the potential health impacts. ***If one or both remaining mandatory measures were removed, what additional measures or actions (if any) would you recommend to mitigate the impacts of this change on your sector or community?*** • During the peak of the Omicron wave, three tranches of Pacific Aotearoa Community Outreach (PACO) funding were administered by

	the Ministry to enable more frequent and responsive engagements between government and Pacific communities to keep Pacific peoples informed and supported during the country's response to COVID-19. This funding: ○ helped to ensure Pacific communities were kept informed and safe from Omicron, and compliant with the COVID-19 Protection Framework; ○ enabled Pacific groups, churches, providers, and community partners to scale up impact, deliver innovative approaches, targeted and holistic initiatives and programmes that respond appropriately to the needs and issues Pacific peoples are navigating with the evolving impact of COVID-19; ○ supported the dissemination of Pacific specific-information and messaging to Pacific communities, including messaging in Pacific languages through translated materials and delivery on ethnic-specific community radio programmes; • Masks and RATs should remain free and easily accessible so that those who require and still want to use them. • A region-specific approach, like the one adopted in the PACO programme, should be taken to ensure the individual needs of Pacific communities around the country are met. • Given Pacific peoples are over-represented in co-morbidity health stats, Pacific communities should also be provided with translated messaging about rheumatic fever, Flu, Measles, all which impact our Pacific communities immensely.
Ethnic communities	***<u>Status quo:</u> Cases continue to be required to self-isolate for 7-days*** • 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. • The continuation of the status quo could negatively impact some small ethnic business owners, with winter approaching, subsequent COVID-19 waves and potential staffing shortages. • In addition, MEC has received feedback that access to the COVID-19 leave support scheme has been varied in some communities. For economically vulnerable ethnic communities, this is a major 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 some reassurances to some ethnic communities who are vulnerable to COVID-19 such as the elderly and those with an underlying health condition(s). ***<u>Status quo revised:</u> People who are symptomatic for 1 day or less be permitted to leave isolation at 5 days***

	• MEC notes allowing people who are asymptomatic for 1 day or less to be permitted to leave isolation at 5 days could potentially benefit some small ethnic business owners as they may not have to plan for as significant staffing shortages with subsequent waves. • MEC also notes the status quo revision may result in some concerns from some ethnic communities who are vulnerable to COVID-19 such as the elderly and those with an underlying health condition(s), as there is still a perceived risk for these groups. • MEC recommends that communications for any proposed permitted movements or other rules should be consistent, simple, and clear. There has been feedback from some ethnic communities that previously some key health messages were confusing as they contradicted other key messages or were unnecessarily complicated. This may increase compliance with measures. • To improve compliance, MEC recommends communications should be translated in numerous languages. ***<u>No mandatory isolation:</u>*** • MEC notes that no isolation requirements could potentially benefit some small ethnic business owners as they may not have to plan for as significant staffing shortages with subsequent waves. • MEC notes 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 is 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 the eligibility of COVID-19 leave support scheme for employees who choose to self-isolate could improve compliance. • MEC notes the removal of mandatory isolation requirements may result in some concerns from some ethnic communities who are vulnerable to COVID-19 such as the elderly and those with an underlying health condition(s). • MEC also 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.
Young people	We support retaining this measure as a key protective mechanism, particularly for vulnerable communities. There is good evidence of its effectiveness and provides certainty.
MBIE tourism	MBIE Tourism does not have a preferred option, but we do think it is important for Ministers to understand that the self-isolation requirement can be

	problematic for international visitors. Over time this is likely to increase the attractiveness of other destinations that don't have these requirements relative to NZ which will have an economic impact (it is very hard to estimate this given all the other disruptions/factors influencing international travel). We have received examples from the industry including: • Someone paying $1000 to taxi from Te Anau to Dunedin in order to isolate, as there was no accommodation in Te Anau and the bus operator was not prepared to let them stay with the other tour members on the bus • Travellers being hit with $400-$500 a night room rates when they book their isolation stay, as the dynamic pricing model used by hotels has very high charges when you don't book in advance • Travel insurance won't cover the full cost of these changes plus airfare changes We don't know what share of positive cases are from international visitors, and so we can't comment on the proportionality of the current approach for international visitors. We do note that the FIFA Woman's World Cup will be held in NZ and Australia in July/August, and forecast visitor numbers will mean that this is a much busier winter than usual (albeit still fewer people than a normal summer season). The high profile nature of this event, volume of additional visitors, and likely price increases may mean that more public attention is given to issues such as the ones raised above.

Operational considerations

Agency	**Operational considerations**
Te Whatu Ora	***Option 1: Status quo*** No change. Continued costs to enable Alternative Isolation Accommodation and Community Connectors across the 7-day period. Our ability to continue to support the COVID-19 response, including those who are required to isolate, is contingent on funding for COVID-19 beyond 30 June 2023. If funding is available the national case investigation service will continue to focus on contacting priority populations to enable support where required and facilitate access to antivirals where indicated. Services currently include, but are not limited to, case management, telehealth and Alternative Isolation and Accommodation services. ***Option 2: Status quo revised – people who are symptomatic for 1 day or less be permitted to leave isolation at 5 days*** Need to understand what changes, if any are proposed for household contacts here – it was suggested in the PHRA that household contacts would shift to testing if symptomatic only but it is not clear here if that option is still being considered. Household contacts are the only asymptomatic people who should

	be testing. Changes will household contacts and testing expectations will affect associated guidance and comms. *Guidance and content* All existing comms will need to be reviewed and changed to outline the differing requirements for isolation depending on symptoms. Substantial revision of comms to both explain what being asymptomatic means and to explain why having symptoms for a day is different to having symptoms for more than a day- and what symptoms we mean. Communications will need to be clear so confusion is minimised and the general public understand what is required of them. Operationally, we would need to work through advice for those who test positive. What happens if you don't have symptoms when you test (because you are a household contact) but develop symptoms after that. How do we communicate the difference in advice on isolation if that occurs? This change may be more difficult to communicate than a test to release process. Changes to web content and updated guidance should be socialised with our Treaty partners and put into accessible formats and translated. Significant re-training of staff providing telehealth services would be required to ensure that consistent advice is given out – particularly since this will be based on subjective assessment of individual symptoms; some people will inevitably be confused and will seek further advice on what to do. Different members of same households likely to have differing pathways (i.e some people for 5 days and some people for 7). Review of technology is required, particularly of SMS messages which currently specify isolation period for cases – as won't be able to differentiate between symptomatic and asymptomatic. *Funding* Our ability to continue to support the COVID-19 response, including those who are required to isolate, is contingent on funding for COVID-19 beyond 30 June 2023. If funding is available, the national case investigation service will continue to focus on contacting priority populations to enable support where required and facilitate access to antivirals where indicated. Services currently include, but are not limited to, case management, telehealth and Alternative Isolation and Accommodation services. ***Option 3: No mandatory isolation*** Voluntary isolation under the Health Act would become the norm. A requirement to isolate is still possible though this would have to be managed by medical officers of health at PHSs, who would need to issue individual orders if/when required to support cases or enforce due to a public health risk. As a comment for Outbreak Response, we note this could have a significant impact on the number of people flowing through ED and Hospital Settings and more work will be required with Hospital Specialist Services (HSS) to better

	understand the operational impacts. We note the request has gone to HNZ Government Services, who may capture comments from HSS. Health guidance for employees around off work requirements may be necessary and Te Whatu Ora will need to work with MBIE. Te Whatu Ora will need to issue guidance to Health care workers about off work requirements. The existing health care guidance would need changes and there are paid leave considerations(Guidance for return to work of healthcare workers (PDF, 1.3 MB)). The guidance should align with the testing plan being reviewed with the lens of winter planning. Consideration will need to be given as to whether the national case investigation service will continue in its current form; dependent on whether test results will still be required to be reported. May need to develop alternative pathways for priority populations to enable support (if available when there is no mandate) and facilitate access to antivirals where indicated. If the mandate is removed, then the assumption is testing will decrease, therefore reducing demand on RATs and increasing obsolescence cost. *Guidance and content* All existing comms will need to be reviewed and changed to recommend voluntary isolation. New guidance for many sectors will need to be produced to ensure management recommendations are proportional to the risk -eg consideration of using a test to release scenario for high risk settings such as ARCs. Or we will need to provide clear guidance that high-risk settings (for transmission) continue to apply a 7 day isolation period. If different guidance is going to be applied to different sectors then requirements need to be agreed in advance and guidance developed in advance of any changes. A new CD manual chapter will need to be developed in advance of mandates being removed – with appropriate consultation with PHS, clinical teams, Te Aka Whai Ora, Whaikaha etc. This will need to be supported by appropriate comms. Changes to web content and updated guidance should be socialised with our Treaty partners and put into accessible formats and translated. *Funding* Our ability to continue to support the COVID-19 response is contingent on funding for COVID-19 beyond 30 June 2023. Further consideration is needed for the services that would still operate without mandatory isolation, including supports for those who are unwell and priority populations. *Antiviral eligibility if isolation removed* Te Whatu Ora has suggested that there should be a review on whether there is new evidence to support eligibility being reduced or widened (as opposed to only considering increasing access). A course of antivirals has significant cost, and Te

	Whatu Ora would need to be assured the cost benefit stacks up when placed against all the other investments Te Whatu Ora could make.
Employment Services, MBIE	If isolation requirements are changed, clarity about public health advice will be important for employees and employers. For example, if people with COVID who are asymptomatic are allowed to leave isolation at day 5, what does it mean if they are still testing positive? If the isolation requirement is removed entirely, there will likely be questions about whether it is safe to work alongside someone who has COVID-19. The more room for interpretation left by the rules/guidelines, the greater the grounds for disagreement between employers and employees (or PCBUs and workers, from a work health and safety perspective).
WorkSafe	WorkSafe supports the response from Employment Services. It is inevitable that various disputes will arise from workers who have very recently had COVID returning to the workplace, in the absence of a mandatory isolation period. These will either be couched within the good faith obligations of the Employment Relations Act 2000, or a PCBU's duties under Health and Safety at Work Act 2015 towards the rest of its staff and/or customers. WorkSafe may need to prepare some standard messages in anticipation of these types of queries once decisions are taken. Before this pandemic, we would almost never have known (or dared to enquire) *why* a particular person was on sick leave unless we knew them very well on a personal level. Other employees were just told that they *were* on sick leave, and no-one felt any obligation to broadly disclose personal health information to explain the reason for their absence. However, these disputes can only arise if someone at work *knows* that the reason the person has been off sick is because they tested positive for COVID. So I wonder if a timely reminder about protection of individual privacy might be helpful?
Transport	If the isolation requirement is removed, MoT would recommend clear guidance is produced for symptomatic cases to isolate; this should also clarify what makes a case 'symptomatic' Case isolation requirements are impacting on existing workforce shortages across the aviation sector which are already under significant pressure. The aviation sector would support a reduction in the period of mandatory isolation to 5-days, 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.
Education	***Early childhood education*** In early learning the removal of mandatory isolation would mean services would manage COVID like other infectious illnesses. We would need health advice on appropriate timeframes for staff and children to stay at home. We currently have

	an infectious diseases requirement in our licensing criteria that details treatment and how long children should stay home eg. flu requirement for children is 'until well'.[1] The criteria is 3rd tier legislation and we will need to update this through a legislative process so that it is clear how COVID should be managed. We also have Regulation 57(2) to manage staff with infections illnesses to protect children – this reg doesn't specify contagious illnesses so won't need amending. In any case we could communicate through guidance initially until any criteria process is through. Option 2 (five days, asymptomatic can leave isolation) would have little operational change from the current 7-day isolation for early learning. S***chools*** School Boards and early learning services are PCBUs (Person Conducting a Business or Undertaking) and have a duty to manage workplace risks, and any potential or actual outbreaks of communicable disease such as influenza, measles and COVID-19, among other health and safety responsibilities outlined in the Health and Safety at Work Act 2015. The Ministry's guidance is that schools should encourage all staff and students who are feeling ill to not attend school. This aligns with schools' health and safety policies and/or school policies. Under section 77 of the Education and Training Act 2020 a principal of a State school may preclude a student from the school if they have reasonable grounds to believe that the student may have a communicable disease (within the meaning of the Health Act 1956).[2] ***Tertiary education*** Comments if case isolation was no longer mandatory: • Tertiary providers will be conscious of their obligations to learners and staff (e.g. 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. • Tertiary providers have told us in the past that they prefer not have to impose their own restrictions where there aren't Government requirements in place – and also that they would rather have a clear

[1] Education (Early Childhood Services) Regulations 2008, Regulation 57 is focused on the health and safety of children. The criteria are based on the Regulations and set out the day-to-day standards that services must follow in order to retain their licence or certificate. There are different criteria for different service types (for centre-based education and care services, home-based, hospital based education, kōhanga reo, and playgroups) https://www.education.govt.nz/early-childhood/licensing-and-regulations/the-regulatory-framework-for-ece/#Regulations

[2] https://www.education.govt.nz/school/health-safety-and-wellbeing/health-and-wellbeing/communicable-diseases-in-early-learning-services-and-schools-a-guide-to-legal-powers/#ForEarly

	government mandated restriction for longer, than to have frequent changes or have to impose their own restrictions.
Corrections	If mandatory self-isolation is removed: • For staff we will likely continue to support frontline staff to encourage them to stay home when COVID-19 positive • For positive prisoners we will likely continue to isolate them from the rest of the prison population to reduce the risk of transmission using provisions within section 60 of the Corrections Act 2004. Corrections has a unique operating environment, especially in the prisons. Our approach to date has focused on minimising transmission of the virus, particularly in prisons, to protect staff and any clinically vulnerable people we manage – research indicates that Māori, Pacific, and disabled people are especially vulnerable due to a range of underlying health conditions. Since the beginning of the COVID-19 pandemic, Corrections has worked to stringent control settings, which have been used to successfully manage the key risks associated with the virus. This has included requirements and guidance for PPE use, the management of positive cases through isolation, isolation of household-like contacts and arriving prisoners, and screening procedures. Our COVID-19 controls are premised on the principles of increasingly focusing effort on the minimisation of severe harm for our most clinically vulnerable groups and recognition of the benefits of reducing the potential for COVID-19 to spread within prisons. This balanced approach reflects the changing nature of the risk that we have experienced in prisons over the past two to three years. ***Corrections actions for staff if the mandatory self-isolation period is removed*** It has been Corrections' policy that if an employee tests positive for COVID-19 or is required to provide care for a dependant who is sick with COVID-19, and is unable to work from home, they would be • entitled to special leave on pay if they work in a prison or in the community until they receive the necessary clearance to return to work, or • if a corporate staff member, then sick leave would apply, or if no sick leave is available then discretionary leave policy would apply. This policy has supported our efforts to keep the vulnerable people we work with safe from contracting COVID-19 while in our care. We recently reviewed our settings around special leave and at this stage we are retaining special leave for the time being. This will provide the best protection from further transmission of COVID-19 to our vulnerable people leading into the winter season. Once the mandatory self-isolation requirement is removed, we will continue to monitor the situation, including any changes in the public health advice, and adjust settings as needed for our unique environment. Any change in approach to leave will need to be assessed against our risk framework to ensure there are sufficient controls in place to support the health

	and safety of our staff and the people we manage. We will also continue to reinforce the message to staff to stay home if unwell. ***Corrections actions for prisoners if the mandatory self-isolation period is removed*** Under section 60(1)(a) of the Corrections Act 2004, prisoners can be segregated for the purpose of medical oversight in order to assess or ensure the prisoner's physical health. This means they can be quarantined to manage an infectious disease if clinically recommended. Currently if a prisoner tests positive for COVID-19 they complete their self-isolation in their cell supported by our health and custodial staff. If the mandatory period of self-isolation was to be removed, we would likely continue to isolate COVID-19 positive prisoners using the provisions within the Corrections Act to minimise the risk of further transmission. We will be guided by public health advice and clinical judgement regarding the length of time someone remains in isolation. For this reason, we anticipate that any public health change to mandatory requirements would also be accompanied by guidance for agencies such as ourselves about managing any ongoing risks.
Ministry of Justice	Thank you for the opportunity to comment on this paper. Our comments are relatively brief due to time constraints. If there is anything we can expand on, please feel free to reach out. • From a human rights perspective, we recommend that you include a broader analysis of human rights implications, including all proposals and considering wider impacts (e.g. going beyond legal compliance/risk). For example, we note that removing the mask mandate in healthcare settings may reduce limits on freedom of expression. The human rights section of your paper should also consider the expected impacts of the proposals on vulnerable populations, as noted elsewhere in the paper. • We note that retaining the 7-day isolation requirement will have an impact on court delays/timeliness due to staff sickness and matters being adjourned/rescheduled, though measures can be taken to minimise disruption.
Police	We have not identified any significant impacts for Police regarding the proposals and have no particular comments on the paper.
MSD Regional Public Service Commissioners	***Feedback from Nelson, Tasman, Marlborough and the West Coast*** The general population is not concerned with the settings, with many people unaware, or ignoring the isolation and reporting rules. With the reduction in Covid services, the need for isolation would likely get some push back from across the West Coast if it was not lessened or dropped Isolation does give added protection for workers to take the full requirement of time needed and lessens the spread. However there is the potential impact on businesses or workers who are unable to afford the time out of work. Irrespective on the decision to remain at the current level, or make changes our key feedback is around the need for simple, clear and visible rules. For example: • Many in our community are unaware that Covid restrictions are still in place • Who determines asymptomatic?

	• Confusion exists around household contacts. • To support the credibility of the government clarification of who enforces the rules would be valuable. Should restrictions be removed there is a need for increased messaging around: • What to look for, • Self-care, • Clarity (and promotion) around the boosters available ***Feedback from the Auckland region*** Our preferred option is option 3: no mandatory isolation. This enables a self-care model. If this is not the preferred option then option 2: status quo revised – people who are asymptomatic for 1 day or less be permitted to leave isolation at day 5. This option will require very clear communication and guidance as we find there continues to be a misunderstanding of the current measures. From an operational perspective removing the measure to self-isolate might result in those unwell and in employment going to work if they will not be paid (no available sick leave etc). Retaining the current Leave Support Scheme would mitigate this potential risk. Note, this can be applied in many other instances apart from COVID where people in employment are unwell and unpaid when absent from employment. Welfare support, which is generally food related can be managed through a business as usual approach through the Work and Income general line – 0800 559 009. ***Feedback from the Otago and Southland RLGs*** All members (except one) who responded, supported option 2. One member supported option 3. Comments included: • This needs to be considered in the context of current prevalence • Stood for an hour to get through a checkout at the supermarket with staff off sick. Still high numbers of staff off work. • Need to consider that winter is looming (and people in NZ are terrible for working when sick) • The need to be guided by Health • Option three needs consideration as anecdotally a lot of people aren't reporting in order to avoid the isolation period and giving distorted figures of spread in the community • Appears that the lack of symptoms is the key after the event, people are often unaware when they are infectious beforehand and it is difficult to stop this period which is when people are most likely to pick it up from each other • Masks should be forever in health settings • Masks are important to protect the most vulnerable in health locations

	and as we head into flu season • Consideration needs to be given to impacts on our vulnerable communities. ***Feedback from Taranaki Public Service Leaders' Forum*** • Option 1 Status Quo – 5 votes • Option 2 -1 vote • Option 3 – 1 vote Around self-isolation there were some things to consider if moving away from Option 1 • We could move to option 3 with significant public health promotion behind staying home if you are unwell, targeting employees and more importantly employers. People who have contracted Covid 19 should still isolate until they test negative. People who are ignoring the current mandates for whatever reason will continue to do so, with the majority of people, now ready to take personal responsibility and act in an appropriate manner • While public promotion could assist with people doing the right thing, evidence shows this is highly unlikely and many employers are so short of staff they can't afford to have too many people away for seven days. Anecdotally some say if you test negative come on back. ***Feedback from MSD Central region*** • Mindful that MSD is focussed on the wellbeing outcomes of whanau, by supporting entitlement and financial assistance, this response is not grounded from a health perspective. • MSD across the central region will follow guidance from health and te whatu ora to uphold and support the required changes. • Both our front line and regional office staff have effective lines of communication and systems to uphold the integrity of each of the options. When client facing staff encounter whanau or clients, this messaging can also be conveyed. We will continue to follow the guidance and develop adapted processes to match and support the needs of our clients and whanau, whilst keeping our staff safe and well. • Processes and support around our actions are outlined in our regional business continuity plan. This plan is a living document and continues to evolve. ***Feedback from Waikato RPSC*** Compliance across measures is compromised when complexity is introduced. If there is a subjective element to whether or not people need to isolate it will cause confusion and lead to people leaving isolation early, with no recourse available to those around them. Information to the public needs to be **clear, concise, and compelling** to avoid confusion and non-compliance. Those who are economically vulnerable will be negatively impacted by the removal of isolation requirements, as they may be more likely to return to work when sick if they do not have access to the Leave Support Scheme or other community support due to their isolation status.
MSD	**Status quo**

	• No operational impact noting that funding ends June 2023. <u>Population impact – Seniors</u> The risks (real and perceived) of any COVID-19 resurgence fall disproportionately on older people. The converse is that public health measures aimed at limiting the spread of COVID (such as masking or self-isolation requirements) will benefit older New Zealanders. **Self-isolation with permitted** A scenario where a decision is taken to permit movements for those people who have tested positive for COVID-19, would have some impacts for more vulnerable people we're working with, and would have impacts for our Service Centres, including the safety and wellbeing of our staff and clients. **No mandatory isolation** • COVID food parcels will cease. Community Connectors will still be able to support COVID impacted. If mandatory isolation is lifted then no further CiC funding will be provided to sector except as agreed for transition. Community Connection Service FTE will remain in place and providers will continue to support covid impacted households with remainder of funding available to their organisation until 30 June 2023. • A scenario where a decision is taken to remove self-isolation requirements would also have considerable policy and delivery implications for the COVID-19 Leave Schemes. Demand for LSS continues to remain with Approximately $2.7 million paid out, and over 3,200 application approved, in the seven days prior to 17 March 2023. However, there are existing redeployment assistance MSD may be able to offer. Once LSS is closed, applications will still be accepted up to 8 weeks from the date of closure. • MSD already delivers extensive hardship support and can provide employment services to support people to redeploy into more sustainable employment opportunities MSD would close some of its COVID-19 0800 numbers with no mandatory solation.
DIA	DIA would like to highlight the following points: • territorial authorities provide a range of public services to their communities, and administer several public access areas/facilities (i.e: libraries, pools, community centres). We note that the paper does not provide any details about how these proposals could impact on facilities and services delivered by local authorities, particularly those whose majority populations are comprised by the same vulnerable groups that form the basis of the paper's proposals. Because the RIS was not appended in this consultation, DIA is unable to assess whether this analysis was presented as part of the risk assessment process. • Noting time constraints, DIA recommends that MOH officials engage with local government representative groups to discuss potential impacts of the proposals on the sector. Our comments related to high level impacts on local authorities in their service delivery functions. If the thinking is that retaining settings is advisable, and if the impacts on the sector have been considered in previous advice when these settings were originally put in place, then all the paper needs to do is state it.

MFAT	No comments

Appendix 3: Masks for visitors in health service settings – impacts on populations and operations

Population impacts

Agency	Response in relation to proposed option
Te Aka Whai Ora	***The impact of changes to public health restrictions on Māori is unknown*** There is currently insufficient information available to properly assess the likely impact of changes to public health restrictions, such as mask requirements in healthcare settings. While Manatū Hauora prepared papers for the PHRA committee that detailed key data, trends and forecasts relevant to the assessment, the information available primarily focusses on the whole of the population, rather than specific population groups. No other evidence was considered by the committee which quantified the impact of potential changes to public health restrictions on Māori. It is not sufficient for the Crown to rely on whole-of-population data or modelling to determine the appropriateness of changes to public health restrictions that may have a disproportionate impact on Māori. Without an appropriately thorough evidence base about the impact of policy settings on Māori, it is not possible to make an assessment of the effectiveness of those settings (such as a mask mandate) or the impact on Māori if they were to be changed. As a result, the view of Te Aka Whai Ora committee members was that there was insufficient information available to fully assess the impact of the potential changes to public health restrictions on Māori, or other population groups facing systemic disadvantage (such as people with disability or Pacific peoples). ***For this reason, Te Aka Whai Ora recommends making no changes to public health restrictions until a more thorough assessment can be undertaken*** Te Aka Whai Ora considers that, in the absence of an adequate analysis of the impact of potential changes to public health restrictions on Māori, it is not appropriate for the Government to make a decision to change the existing restrictions around the use of masks in healthcare settings or self-isolation of COVID-19 cases. COVID-19 remains a significant issue for Māori, accounting for 4% of all Māori deaths in New Zealand in 20223 or about 21.5 deaths per 100,000 Māori per year. Te Aka Whai Ora's advice is that the existing settings are retained for the time being, and that Te Aka Whai Ora works with Manatū Hauora as a matter of urgency to ensure that proper consideration can be given to the impact of COVID-19 and the Crown's response to it on Māori and other population groups as part of the next regular PHRA.
Te Puni Kōkiri	We do not support the revoking of masks in health service settings. Aligned with the concerns and issues identified by Te Aka Whai Ora, we believe that this could have negative impacts on vulnerable communities, immune compromised whānau, and Māori who are overrepresented in negative health statistics. We support the recommendation made by Te Aka Whai Ora that no changes should

[3] This is based on a comparison of Māori deaths reported by Stats NZ in *Monthly death registrations by ethnicity, age, and sex: January 2010 to December 2022*, and Māori deaths reported in 2022 by Manatū Hauora as attributable to COVID-19.

	be made within this area until a thorough assessment has been conducted – especially one that isn't too reliant on anecdotal evidence as the paper suggests. We would also recommend status quo to continue to monitor the impact of new variations internationally and to assess the potential impact of flood disturbance and increased crowding that usually follows such events.
Te Arawhiti	We support the retention of current mask wearing requirements and, as always, would support the expansion of mask wearing requirements to public transport. The reintroduction of mask wearing requirements on public transport would signal 'higher risk' and may drive more precautionary approaches across communities, meaning this expansion could also positively impact the prevalence of voluntary health behaviours that influence transmission.
Ethnic communities	***Status quo:*** MEC notes the continuation of the status quo may give some reassurances to some ethnic communities who are vulnerable to COVID-19 such as the elderly and those with an underlying health condition(s). ***Remove the mask mandate:*** MEC notes no mask requirements could result in concerns from some ethnic communities who are vulnerable to COVID-19 such as the elderly and those with an underlying health condition(s).
Whaikaha (Disabled people, including tāngata whaikaha Māori)	COVID-19 has exposed the existing inequities that disabled people face in their everyday lives. About 24% of the New Zealand population identified as being disabled in the 2013 Disability Survey. As disability is not recorded on a person's NHI number, where most COVID-19 data and insights are obtained, it has been difficult to gain a full picture of the impact of COVID-19 on all disabled people. However, we know that disabled people experience particular risks associated with co-morbidity of health conditions. Disability Support Service (DSS) recipients are likely to have more complex needs, a medical condition which puts them at greater risks, live with other people, and receive support that requires close contact with other people. One-off analysis undertaken by Manatū Hauora and Whaikaha showed that people receiving DSS have been at greater risk of severe outcomes (hospitalisation and death) due to COVID-19, over the period 1 January – 16 November 2022. These risks are significantly greater for people who receive residential support (47 times higher mortality, and 8 times higher hospitalisation). Whaikaha's view is that a step-down in the current measures will place disproportionate impacts on disabled people and their whānau to keep themselves safe. This may mean that more disabled people and their whānau withdraw from participating in their communities and may not seek essential healthcare. To ensure disabled people and their whānau have the confidence to participate in their communities, we recommend the following steps are taken before a decision is made to step-down from the remaining protective measures:

	• Consultation with the disability community, in line with the UN Committee on the Rights of Persons with Disabilities' 2022 recommendation 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". • A commitment to regularly collect, monitor and model case rates, hospitalisation rates, and mortality rates for DSS clients. Complementary to these steps, Whaikaha encourages: • Disaggregated data collection on antiviral and vaccination uptake, and the prevalence of Long COVID-19. • A public awareness campaign targeted at encouraging positive COVID-19 behaviours (masking, social distancing) to protect at-risk population groups, including disabled people. • Greater support for the vaccination workforce to ensure COVID-19 vaccinations are accessible and responsive to the needs of the disability community. If a decision is made to amend the current settings, Whaikaha recommends that: • Decisions are communicated in accessible formats, at the same time as communications to non-disabled people. • Minimum ventilation standards are established and communicated to people, to enable informed choice and control over COVID-19 exposure risks. • Masks and COVID-19 tests remain free and easily accessible so that those who require and still want to use them. • Infection control training is designed and delivered for both the regulated and non-regulated health and disability workforces.
MPP	***Any advice on what may improve compliance with the measures*** • If mask requirements are removed from the mandatory measures, we recommend disseminating communications translated into the nine languages supported by the Ministry to ensure Pacific peoples are aware of the change and can respond accordingly.

Operational considerations

Agency	**Feedback**
Te Whatu Ora	***Option 1: Status quo – required for people who are visitors to health service settings*** No change. Work is underway to review Infection, Prevention and Control guidance (IPC). ***Option 2: Remove the mask mandate – issue updated guidance to healthcare providers*** All stakeholders will need to be on the same page about how policies for mask are established and enforced.

	A national document that provides key guiding principles and considerations to enable facilities /policy makers or specialist groups responsible for this area would be key to enable national consistency, but some flexibility given the different services, risks and needs within facilities that provide healthcare. Advice has been drafted previously that addresses some of these points. The advice/document would need to be reviewed and receive endorsements. As there are several different sectors to engage with, this would not be a fast process. Decisions need to be made on whether we take a central approach to supporting the sector that articulates how we expect this to work at a local level and specific guidance for vulnerable groups. This may include information around criteria for assessing risk and determining when masks could be required, which would need to be developed with consultation. There would be no impact to the supply of PPE to healthcare providers for healthcare, as this isn't covered by the current masking mandate and PPE requirements are covered by IPC guidance and Health and Safety legislation. Supply of PPE from the Te Whatu Ora COVID-19 Central Supply to publicly funded health and disability services would continue until we commence transitioning PPE supply arrangements away from the centralised supply and distribution model to a model where healthcare services source and fund their own PPE as a regular provider/business cost. From a supply and logistics perspective, the primary impact is whether free medical mask supply for the general public and N95s for vulnerable populations continues. Masks are currently accessible from RAT collections sites when collecting RATs and through equity distribution networks. Based on current SoH (and no further purchasing) we could continue to supply medical masks until September 2023. There are no supply constraints for N95s. *A total 4-6 week implementation period would the minimum, and allow for resources to be published (including translations). It allows for a managed transition and services to consult on policies e.g. with their employees if necessary.*
Corrections	Corrections is not currently covered by the mandatory mask requirements; therefore, there will be no change in policy to accommodate the change. We will continue to require masks in the operational environments that have been assessed as the highest infection risk; noting all operational policies are subject to change taking appropriate health and health and safety advice into consideration.
MSD Regional Public Service Commissioners	***Feedback from Nelson, Tasman, Marlborough and the West Coast*** Mask wearing in health situations does not appear to have any issues, and with winter coming up, and a shortage of doctors in the region it seems logical to leave mask mandates in place for medical practices. ***Feedback from the Auckland region*** Option 1: Status quo – required for people who are visitors to health care setting.

	Feedback from the Otago and Southland RLGs All members who responded supported option 1. ***Feedback from Taranaki Public Service Leaders' Forum*** Masks everyone united in maintaining the status quo with masks. ***Feedback from Waikato RPSC*** • If the mandatory isolation requirement is removed, mask use in healthcare settings should remain mandatory. The use of masks has kept rates of transmission lower than they otherwise would be, and encouragement of their use in limited settings should be kept. • However, **removing** the mandatory measures would be easier from an operational perspective **rather than revising** existing measures. Additional measures required would be increased public information campaigns around the use of masks as a precaution in healthcare and other settings, increased access to masks and other supplies for healthcare providers, and increased promotion and availability of the second booster as uptake rates for this are currently sitting at around 15% of the total population (compared to over 50% for the first booster).
MSD	***Status quo*** No impact. ***Removal*** <u>Population impact – Disability</u> We advise against removing the requirement of masks for disability and health services, given the number of people in these spaces that may be more vulnerable to COVID-19.
Oranga Tamariki	We note the rationale to move away from broad emergency measures and towards responsibility sitting with individual health care providers. However, we have reservations about removing this measure due to: • potential for disproportionate/inequitable adverse health impacts (and flow on social and wellbeing impacts) for vulnerable communities such as Māori, Pacific, and disabled people • potentially reduced protection for children and young people, particularly those more vulnerable due to being unvaccinated • potentially increased strain on the health system (resulting from the above impacts) which is already facing higher-than-normal demand, and especially as we head into the winter period – as articulated in the Public Health Risk Assessment. • increased tension and confusion for caregivers/parents/guardians around using masks in healthcare settings (e.g. differing opinions between caregivers and parents) • lack of population specific data available to inform this decision – as already articulated by Te Aka Whai Ora and Whaikaha (paras 70-72) We also note that while children and young people may not be at greatest risk of contracting COVID-19 or experiencing the worst health outcomes from COVID-19 (compared to other age groups), removal of this measure may increase the risk of children and young people spreading COVID-19 to more vulnerable people

	in their communities. If this measure was removed, we would support the proposed mitigation – i.e. "clear guidance for health service providers" (para 69). However, we suggest this is expanded on if possible to give further assurance – e.g. in line with Te Whatu Ora feedback (pg 34) which states that the guidance should include "a national document that provides key guiding principles and considerations to enable facilities /policy makers or specialist groups responsible… to enable national consistency, but some flexibility given the different services, risks and needs within facilities that provide healthcare"

Appendix 4: POCT Order – population and operational impacts

Population impacts

Agency	Feedback
TPK	We have not identified any substantive issues in this proposal.
Oranga Tamariki	We are comfortable with this proposal.

Operational considerations

Agency	Feedback
Customs	Customs has no issue with the proposal to revoke the POCT Order. The key issue for us is the timing of the revocation of the POC Test Order for implementation purposes. ***The current operational impact of the import restriction: low to negligible*** We have been encountering very few consignments this year (we have only had three to triage this year, a vast improvement on the twenty a day for a while last year). ***Going forward – the revocation logistics*** Customs would appreciate being advised at the same time (or before if possible) that the revocation occurs, in order that we can frontline officers and MPI of the revocation. MPI Target Evaluators have been an exceptional valuable partner in this area for Customs, referring over 600 shipments of unauthorised tests to us (which we would have been unlikely to have identified in our data otherwise). As far as we are aware we have no active ROS in respect of these goods

SWC-23-MIN-0032

Cabinet Social Wellbeing Committee

Minute of Decision

COVID-19 Public Health Measures

Portfolio **Health**

On 5 April 2023, the Cabinet Social Wellbeing Committee **referred** the submission under SWC-23-SUB-0032 to Cabinet on 11 April 2023, revised as appropriate given discussion at the meeting.

Rachel Clarke
Committee Secretary

Present:
Rt Hon Chris Hipkins
Hon Carmel Sepuloni (Chair)
Hon Kelvin Davis
Hon Grant Robertson
Hon Dr Megan Woods
Hon Jan Tinetti
Hon Dr Ayesha Verrall
Hon Willie Jackson
Hon Kiri Allan
Hon Peeni Henare
Hon Priyanca Radhakrishnan
Hon Kieran McAnulty
Hon Ginny Andersen
Hon Barbara Edmonds
Hon Willow-Jean Prime
Hon Rino Tirikatene
Jo Luxton, MP

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