CAB-23-MIN-0259

Cabinet

Minute of Decision

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Report of the Cabinet Social Wellbeing Committee: Period Ended 23 June 2023

On 26 June 2023, Cabinet made the following decisions on the work of the Cabinet Social Wellbeing Committee for the period ended 23 June 2023:

	Out of scope	
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	Out of scope	
SWC-23-MIN-0070	**COVID-19 Public Health Measures** Portfolio: Health	CONFIRMED
	Out of scope	
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Out of scope

for Secretary of the Cabinet

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Cabinet Social Wellbeing Committee

Minute of Decision

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COVID-19 Public Health Measures

Portfolio **Health**

On 21 June 2023, the Cabinet Social Wellbeing Committee:

Background

1 **noted** that in April 2022, Cabinet agreed to retain the mandatory COVID-19 public health measures of seven-day mandatory self-isolation for cases and masks for visitors to health services [CAB-23-MIN-0136];

2 **noted** that there is an authorisation under section 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, and masks for visitors to health care settings, until 30 June 2023;

3 **noted** that the Prime Minister will receive advice on renewing the section 8(c) authorisation, as required, in the week beginning 19 June 2023;

Review of case isolation requirements

4 **agreed** to retain the status quo of 7-day mandatory self-isolation for COVID-19 cases;

5 **agreed** to discontinue the provision of free RATs at airports to travellers arriving from overseas from 1 January 2024;

Review of government mandated mask requirements

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

Next steps

7 **noted** that COVID-19 response settings will be reviewed again in August 2023.

Rachel Clarke
Committee Secretary

Attendance (see over)

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Present:
Rt Hon Chris Hipkins
Hon Carmel Sepuloni (Chair)
Hon Dr Ayesha Verrall
Hon Willie Jackson
Hon Priyanca Radhakrishnan
Hon Kieran McAnulty
Hon Ginny Andersen
Hon Willow-Jean Prime
Hon Rino Tirikatene
Hon Jo Luxton

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

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In Confidence

Office of the Minister of Health

Cabinet Social Wellbeing Committee

COVID-19 public health measures

Proposal

1 Following a review of the public health risk in relation to COVID-19, this paper proposes the following changes to COVID-19 public health settings:

1.1 amending the self-isolation requirements to enable a case who tests negative on a rapid antigen test on days 6 or 7 of isolation to be released from isolation ('test-to-release')

1.2 revoking the requirement that visitors to health service settings be required to wear masks.

Relation to government priorities

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

Executive Summary

3 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 with the public, and maintain ongoing surveillance.

4 Under section 14(5) of the COVID-19 Public Health Response Act 2020 (the COVID-19 Act) the Minister is required to keep all measures under review.

5 To support this, in late May 2023, Manatū Hauora undertook a public health risk assessment (PHRA) to review current COVID-19 settings. This process led to the development of public health advice from the Director-General of Health (the Director-General) (see Appendix One). This advice recommends:

5.1 retaining mandatory isolation of cases for 7 days

5.2 revoking mandatory use of masks for visitors to health services.

6 If retaining mandatory isolation for 7 days is not preferred, the Director-General has indicated a secondary preference for a test-to-release model,

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which would enable cases who test negative for COVID-19 on days 6 or 7 to be released early from isolation. This is my preferred option.

7 The health system continues to experience high demand, which is expected to increase over winter. Retaining some form of mandatory case isolation is likely to reduce the additional burden on the health system over the winter period.

8 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.

9 In this context, retaining the mandatory requirements for cases to isolate 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. This measure continues to play a critical role to help keep the COVID-19 outbreak manageable.

10 While modelling provided by COVID-19 Modelling Aotearoa suggests that there would be little difference between the health impacts of the status quo and a test-to-release option, there are some concerns that the models may be underestimating the likely impact of moving to test-to-release.

11 As required under the COVID-19 Act, this measure will remain under review. The next PHRA is scheduled for August 2023.

Background

12 The remaining mandatory measures are set out in COVID-19 orders, which may be made under the COVID-19 Act only:

12.1 while an epidemic notice under section 5 of the Epidemic Preparedness Act 2006 is in force for COVID-19; or

12.2 while a state of emergency or transition period in respect of COVID-19 under the Civil Defence Emergency Management Act 2002 is in force; or

12.3 if the Prime Minister has authorised the use of COVID-19 orders.

13 The Prime Minister has authorised the use of COVID-19 Orders until 30 June 2023. The Minister of Health must be satisfied that any order made under the COVID-19 Act is appropriate to achieving the purpose of the COVID-19 Act and does not limit, or is a justified limit on, the rights and freedoms in New Zealand Bill of Rights Act 1993 (the BORA). In April 2023, the Minister of

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Health agreed to retain the following COVID-19 mandatory public health measures:

13.1 7-day self-isolation for cases; and

13.2 mask requirements for visitors to healthcare services.

14 Under the BORA and the COVID-19 Act, the Minister of Health must have regard to the advice from the Director-General of Health (Director-General) about the risks of the outbreak or spread of COVID-19 and the appropriate measures to address those risks and be satisfied that the order is appropriate to achieving the purpose of the COVID-19 Act and does not limit, or is a justified limit, on the rights and freedoms in the BORA.

15 As COVID-19 orders are an emergency measure, used to respond to the risk of an outbreak or the spread of COVID-19, they must be regularly reviewed to ensure that they remain appropriate and justified. The latest review occurred in late May 2023, when Manatū Hauora undertook a PHRA to review the appropriateness of current COVID-19 settings.

Most recent assessment of the outbreak context

The COVID-19 outbreak continues to stabilise

16 Overall, the key measures of infection (levels of viral RNA in wastewater and reported case rates) used to monitor the COVID-19 epidemic have remained fairly stable in most regions since the last PHRA in March 2023, after increasing slightly in April 2023. The 7-day rolling average for new cases for the week ending 4 June 2023 was 1,713. Reported case rates are currently similar to the rates between the August and December COVID-19 waves, and hospitalisations are similar to the level in November 2022.

17 There have been 3,038 deaths attributed to COVID-19 in New Zealand to 11 June 2023, including 472 in 2023. In addition, there have been a further 364 deaths within 28 days of being reported a case in 2023 to date.

Based on information currently available, cases and hospitalisations are expected to continue to oscillate

18 XBB.1.16 ("Arcturus") is now the most common subvariant in New Zealand (24% of cases in the period 29 April to 26 May 2023). 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.

The overall risk is considered to be low relative to other periods of the pandemic...

19 The Director-General has provided advice that the current risk is low relative to other periods of the epidemic and notes that the incidence of hospitalisations has stabilised. Older people, especially those over 80 remain

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at the highest risk of mortality from COVID-19, with older Māori and Pacific peoples being at a higher risk.

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

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

20.1 The total age-standardised hospitalisation rate from January 2023 onwards shows that Pacific peoples and Māori continue to have the highest risks of hospitalisation for COVID-19: 1.5 and 1.6 times the risk of European or Other, respectively.

20.2 Hospitalisation rates for people living in areas of greatest socioeconomic deprivation are approximately two times higher than for people living in the least deprived areas.

20.3 A 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.

20.4 Older people are more likely to have severe illness than younger people. People aged 50 years and above have accounted for 709,192 cases (30% of total cases), of whom 2,983 have died (98% of total deaths) in the period to 11 June 2023.

…and mortality rates for COVID-19 are likely to remain high relative to other causes of death.

21 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. Based on deaths reported for the period from 1 January to 28 May 2023, if the number of deaths attributable to COVID-19 continues at the current rate for the remainder of 2023, this would result in just under 1,100 annual deaths, which would potentially place it as the sixth most common cause of death.

In addition, many eligible people have not yet received their COVID-19 booster

22 Uptake of COVID-19 booster vaccinations has slowed down. As of 28 May 2023, primary boosters' uptake was 73% with 39% of the eligible population having had a 2nd booster.

23 In high-risk populations the uptake is concerning with only 56% of eligible Māori having received a booster dose and 33% having received their second booster. The numbers are also low among Pacific Peoples with 61% of the eligible population having received a booster and 26% receiving both boosters.

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The continued use of mandatory measures

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

25 Over time, the reliance on mandatory COVID-19 measures has reduced to ensure our overall response remains appropriate and proportionate to the risk presented by COVID-19.

Case isolation

26 Under the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 (the Self-isolation Order), cases must isolate for 7 days from the earlier of becoming symptomatic or a positive COVID-19 test.

27 Case isolation has been one of the cornerstone measures of New Zealand's public health response to COVID-19 to date. This measure limits transmission of COVID-19 by reducing the proportion of infectious people having contact with and infecting others in the community, including vulnerable populations.

28 There is evidence that people are more likely to isolate if it is a requirement rather than a recommendation. However, the difference in the effectiveness of the two approaches is probably reducing over time. Removal of the mandate would lead to more infectious cases in the community, increasing overall infection rates, serious illness, hospitalisations, and death.

Masks

29 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.

30 Mask mandates have been an important measure in ensuring high uptake 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.

31 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.

32 Removing the Mask 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 infection prevention and control (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.

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33 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 Mask Order would allow healthcare providers to make mask policies consistent across their facilities and ensure IPC measures remain proportionate to the risks.

34 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 aged residential care (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.

Transitioning to guidance only and the key considerations

35 At a high level, there are three possible pathways to shift from mandatory measures to sustainably integrating management of COVID-19 into the health system:

35.1 **maintain the status quo for both orders** – with a further review in August likely to result in removal at the end of winter provided no significant change in the outlook

35.2 **limited change** – either:

35.2.1 revoke the Masks Order, but retain 7-day case isolation (with a further regular review scheduled for August 2023)

35.2.2 revoke the Masks Order, and shift to a test-to-release model.

35.3 **step-down in case isolation requirements and revoke the Masks Order** – retain the requirement that cases isolate but enable cases who test negative on a RAT on days 6 or 7 to leave isolation early. This approach would still allow for winter pressures to be managed but signal an intent that the approach is changing

36 When considering any changes to the status quo, I have sought to balance the following factors:

36.1 The stabilising context and the need to place management of COVID-19 on a sustainable pathway relative to the value of such changes.

36.2 The disproportionate impact on Māori and underlying Tiriti o Waitangi considerations. This impact is evident in reported cases, hospitalisations, deaths, and is likely to be reflected in similar impacts in terms of long COVID. 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

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to counteract inequitable health outcomes and prevent the impact of COVID-19 from falling disproportionately on Māori.

36.3 The equity considerations for other vulnerable non-Māori populations at higher risk of severe outcomes, including older people, Pacific peoples, disabled people, and people who are immune compromised.

36.4 Minimising pressure on the health system over the winter period. Ensuring that the health system is adequately prepared for the winter is one of my three top priorities for the health portfolio. With winter illnesses already placing pressure on the health system, I do not want to exacerbate the situation through changes to COVID-19 settings that add to hospitalisations.

36.5 Other social and economic impacts concerning the retention of the mandatory measures.

Case isolation

37 I recommend retaining the mandate but shifting to a test-to-release model, whereby cases who test negative on a RAT on day 6 or 7 are able to leave isolation. This change would be a step-down in mandatory COVID-19 measures, an intent signalled by the Prime Minister in April 2023. It would enable a subset of people who are less likely to be infectious to be released from isolation earlier than they otherwise would have.

38 I recommend a lead time of up to two weeks. This will ensure that appropriate communications can be developed. It will also allow time for the public to understand the change and will ensure that RAT supply pathways can support the change.

39 s 9(2)(h)

Public health advice

40 The Director-General has noted that while the incidence of hospitalisations has stabilised, with winter approaching she recommends taking a precautionary approach and retaining mandatory case isolation for 7 days.

41 However, the Director-General has indicated that her second preference would be shifting to a test-to-release approach. Under this option, cases could be released from isolation on days 6 or 7 if they undertake a rapid antigen test and get a negative result.

42 Based on the most recent survey data available, adherence to isolation remains high. A survey series commissioned by Manatū Hauora from September 2022 to February 2023 shows that while intention to self-isolate has remained high throughout this period (85% in November 2022 and

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

43 Nevertheless, the PHRA reviewed a number of options for reducing the period of self-isolation from 7 to 5-days and adding either a test-to-release requirement for days 6 and 7 or limitations on where cases could visit on those days (high-risk settings such as aged residential care facilities and hospitals) as a means to our transition to a guidance only environment.

44 The Director-General has outlined the advantages and disadvantages of the options, and these are summarised in Table 1 below.

Table 1: Comparison of case isolation options

Option 1: Maintain status quo (7-day isolation)	
Advantages	• minimises the number of people who will be infectious on release from isolation (estimated at 19% infectious on release) • the requirement is simple and generally well-understood • is not reliant on a case's ability to access or use a RAT to exit isolation
Disadvantages	• a proportion of cases will remain in isolation for longer than is necessary to protect those at higher risk from infection
Option 2: Amend the mandate to enable test-to-release (cases that test negative on days 6 or 7 able to leave isolation)	

Advantages	• would reflect a step-down in mandatory COVID-19 measures, an intent signalled by the Prime Minister in April 2023
	• would enable a subset of people who are less likely to be infectious to be released 1 or 2 days earlier from isolation than they would under the status quo (estimated 21% infectious on release)
	• help to prepare the public for a future scenario where there are no mandates in place, by:
	  o providing people with the information that could help them to be aware of the risk they may present to others if they leave isolation while still testing positive
	  o preparing employers for the possibility that some may find it useful (and for certain settings it will be advisable) to require employees to test negative on a RAT before returning to work

Disadvantages	• partial change may create uncertainty for the public on when to isolate, and people might interpret the isolation period as having reduced to 5 days, creating additional transmission risk • adds complexity to public messaging – confusion can lead to non-compliance or incorrect compliance, which may lead to a reduction benefit realisation • is reliant on the person's ability to access and use a RAT (or other COVID-19 test) – while RATs are currently available for free from a range of locations, from 1 January 2024 public free supply of RATs will end • the approach may only result in marginal gain – based on data from Canterbury healthcare workers, approximately 1 in 15-20 workers were both asymptomatic and had a negative RAT at day 6

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	• while the relaxing of settings may reduce the time spent in isolation, it will increase the number of infectious people in the community, seeding further cases so the net effect may be lessened • in the context of winter and an expected increase in cases, any actions that increase transmission will also increase hospitalisations, placing further burden on the system

Population impacts

45 It is likely that removing case isolation would result in an increase in cases in some communities and population groups more than others. If there are more infectious people circulating in a community with more baseline contacts, this increases the likelihood of onward transmission. See agency comment section for further information.

Economic impacts [The Treasury]

Shifting to test-to-release

46. The Treasury considers that shifting to a test-to-release policy would have an economic benefit compared to the status quo. Based on the modelling, shifting to a 5-day minimum, 7-day maximum test-to-release policy could reduce the average time in isolation by 1.2 days compared to the status quo, with a small increase in infections (+0.3 to +0.7%) and hospitalisations (+0.4 to +0.5%) and no change in peak hospital occupancy. Being able to return to work sooner would help to ease workforce shortages faced by businesses in the persistently tight labour market. The benefits of reduced isolation days would likely be most acutely felt by small businesses and sole traders, as these businesses have fewer staff available to cover sick leave.

47. Comments from other agencies highlight the impact isolation settings are having on specific sectors of the economy, such as contributing to the pressure that workforce shortages are putting on the aviation sector. In addition, workers would be required to use fewer sick leave days, meaning that they could save sick leave provisions for when they were unwell/infectious in future, which would support people staying home when unwell.

48. The table below presents the estimated labour market impact of alternative isolation policies. These estimates are highly sensitive to the assumptions made. These assumptions are based on historical observations of things such as propensities and abilities to work from home for different industries. As business and employment practices evolve, these propensities will be subject to change. A variety of unknown factors, for example people needing more time off to recover after their isolation period has ended, could alter the actual labour market impact.

Table 1: Estimated labour market impacts of modelled isolation policies

Policy		Hours lost per week	Quarterly cost from loss in hours	Difference from current policy (7 days no TTR)

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	Mean time from 'day 0' to end of isolation period		**worked** (reduction in nominal GDP)	Hours lost per week (% change from current policy)	Quarterly cost
7 days no TTR	7.5 days *	283,400 [149,208, 415,635]	$171m [$90m, $251m]	N/A	N/A
5 days no TTR	5.5 days *	214,227 [111,964, 316,151]	$129m [$68m, $191m]	-69,173 (-24%) [-37,244, -99,484]	-$42m [-$22m, -$60m]
5-7 days TTR	6.3 days	239,074 [125,658, 350,605]	$144m [$76m, $212m]	-44,326 (-16%) [-23,549, -65,029]	-$27m [-$14m, -$39m]

* Calculation assumes that people test positive/experience symptoms part way through 'day 0'.

Note: these estimates are based on modelled case numbers from the weak seasonality scenario. Values in square brackets are calculated using the 95% confidence intervals for modelled case numbers and a compliance range of 33-50%.

Masks in health service settings

49 The Masks Order specifies that masks are legally required for visitors to a wide range of health services.

50 I recommend revoking the Masks Order, with a lead time of up to two weeks. This would also allow for the national guidance to be updated and consulted with affected stakeholders and the development of associated communications to support the change and provider readiness.

51 s 9(2)(g)(ii)

52 Te Whatu Ora has developed National IPC guidance to support the implementation of local IPC policies across the health sector. The approach taken will ensure that visitor policies are consistent and there is not significant local variation unless justified by epidemiology. The guidance will help support providers to develop their own policies.

53 For all settings and services run by Te Whatu Ora (hospitals and services), a single IPC policy has been developed.

Public health advice

54. The Director-General recommends revoking the Masks Order and replacing it with a national recommendation that all health service providers include mask requirements for visitors (along with all other persons) within their infection prevention and control (IPC) policy.

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55. In addition, the Director-General recommends that Government healthcare facilities require visitors to wear masks. Provider policies should provide for the total wellbeing of residents in Aged Residential Care whose need for contact with asymptomatic unmasked whanau members may outweigh risks in private spaces.

56. The Director-General notes that masks remain an important tool to prevent the transmission of COVID-19 and other respiratory pathogens. However, the current Mask Order is providing limited protection from the transmission of communicable diseases. The rationale for the Director-General's recommendation to revoke the mandate is to encourage a more holistic and sustainable approach to mask usage in high-risk settings.

Population impacts

57 Most population agencies explicitly opposed the removal of the visitor mask mandate from health service, due to concerns regarding the potential for adverse impacts on vulnerable populations if the mandate was removed. This includes **Te Aka Whai Ora, Te Puni Kokiri, Whaikaha,** the **Ministry for Social Development**.

58 Other population agencies noted potential concerns with removing the mandate due to the impact that the change could have on vulnerable groups such as older people (**Office for Seniors**), and children and young people (**Oranga Tamariki**).

Economic impacts [The Treasury]

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

Other considerations for changes to for both self-isolation and mask requirements

60 There are several operational implications associated with potential changes to existing case isolation and masking settings. This includes lead in time necessary to implement the changes and dependencies with other measures, including the limited funding available post-winter for current COVID-19 related activities following Budget decisions for 2023/24.

Leave Support Scheme

61 In May 2023, there were 17,592 approved applications under the LSS, and a total of 40,781 cases nationally of people aged 20-69 years. This suggests that approximately 43% of working age cases in May accessed the LSS.

62 The cost of the LSS has reduced in line with the reduction in case numbers, with $15.1 million paid out in May 2023 (compared to $180 million paid out in March 2022). If the scheme remains operational, current funding is likely to be sufficient to last until around October 2023. Over the past three months, the scheme has paid out, on average, $2.6 million per 10,000 cases.

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63 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. Businesses would, therefore, face the full costs of sick leave provisions and some workers, who do not have sick leave entitlements, may not be supported (or have any income) when they are unable to work.

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

65 If the requirement for case isolation ends, MSD recommends closing the LSS. The scheme would not automatically close, as there are eligibility criteria relating to people who have been advised to isolate because they or a household member are at high-risk of severe illness from COVID-19.

66 Closing the scheme would require ending access for the at-risk cohort that have been advised to self-isolate by a medical practitioner. This category of people, as defined in public health guidance, are most at risk of severe illness from COVID-19. Officials are working to ensure applicants are aware of the employment services, income support, and financial assistance for hardship available from MSD.

67 MSD expects that closure of the LSS would result in around $70 million that could be returned to the centre if mandatory self-isolation ends in June 2023. Applications would continue to be received from those eligible for the 8-week period after the final eligibility date.

Care in the Community

68 There were around 2,500 requests for support via the **Care in the Community Welfare response (CiC welfare)** in May 2023. From 1 July 2023, regardless of the decision in relation to self-isolation settings, the CiC welfare model will no longer be in place. Budget 23 continued some CiC supports for 2023/24, but there was no further funding for targeted community supports (Food and Community Connection Service) for households experiencing or impacted by COVID-19 – instead households must seek support through BAU channels. Support continued for 2023/24 includes:

68.1 Maintaining the community food distribution infrastructure – ensuring bulk surplus and rescued food continues to move through the community food distribution system to community food providers to supplement their stocks.

68.2 Some transitional funding for community food providers – this equates to around three months of activity but was not intended to support people self-isolating.

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68.3 Some transitional funding for Community Connectors, with ongoing funding for 100 FTEs to be retained after June 2023 (a reduction from 500 FTEs). This is alongside an additional 65 Community Connectors, who are being retained for one year in regions impacted by the January 2023 floods and Cyclone Gabrielle.

69 If the requirement to isolate remains mandated while CiC related funding ends, MSD considers that this option will place a significant burden on community providers. The inability for people self-isolating to seek support may reduce the impact of the health objectives of this option. If mandatory isolation is removed prior to 30 June, support for COVID-19 self-isolation food parcels will cease immediately.

Supply of free RATs at airports

70 At the same time as Managed Isolation and Quarantine was stood down in early 2022, Cabinet directed officials to provide international arrivals with RAT packs at the airport with information on isolation and testing (getting a PCR if positive).

71 I recommend that free provision of RATs at airports be aligned to free provision of RATs in the community. This would mean that free provision of RATs at airports would end on 1 January 2024. Arriving travellers would still be encouraged to test if they have symptoms (RAT or PCR), and to seek medical care if needed.

Agency feedback on proposals for self-isolation and mask requirements

Isolation

72 Feedback from agencies on further population and sector impacts included:

72.1 concern at the impact that removing case isolation could have on vulnerable populations – including Māori, Pacific peoples, disabled people, and older people

72.2 recommendation that any change be clearly communicated, and provided in a range of formats and languages

72.3 if the mandate was removed: request for health advice in relation to managing settings that are highly regulated and/or where there is a State duty of care, and also clear communication of the rights and obligations of both employers and employees.

73 The Ministry of Education supports an 8-week lead time to enable information to be updated and communicate to the sector regarding the new requirements. It will also enable consequential changes to be made to regulations for licencing of early childhood education centres.

74. Most population agencies support retention of the status quo 7-day isolation due to concern that a reduction could have on vulnerable and/or higher risk

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groups. This includes Te Aka Whai Ora, Te Puni Kokiri, Te Arawhiti, Whaikaha, Oranga Tamariki, and the Office of Rural Communities.

75 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.

76. Sector-based agencies provided feedback in relation to the logistical challenges the requirement to isolate can create. The Ministry of Transport noted that the aviation sector would likely support a reduction to 5-day mandatory isolation, and the Ministry for Primary Industries supports a test-to-release approach. However, the Ministry of Education notes that tertiary education providers support retention of the status quo, rather than frequent changes or having to impose their own restrictions.

77. The Department of Corrections has a strong preference for the continuation of the current mandated public health measures, in particular the current 7-day self-isolation requirement and recommend that any shift in settings should not take place until after the winter season.

78. Agencies whose role involves workplace relations noted that it will be important to provide clear information to both employers and employees on their respective roles and responsibilities if a change was made to isolation requirements. This includes Employment Services within MBIE, and WorkSafe.

79. The Treasury supports a shift away from an isolation mandate in favour of more targeted approaches to managing COVID-19, such as improving vaccination rates. Improving vaccination rates is particularly important for Māori and Pacific peoples, where although initial uptake of vaccinations was very high, booster rates for these groups remain significantly lower than they do for the general population.

80. Isolation mandates had an important role in eliminating COVID-19 in New Zealand, and then following the arrival of Omicron, managing transmission within the available hospital system capacity. However, the Treasury supports a shift away from an isolation mandate now as:

   a. The emergency phase of the COVID-19 response is over: case and hospitalisation rates have been relatively stable since the beginning of this year, and the PHRA notes that "overall public health risk is low and most likely to remain low over the next 6 weeks". Cabinet agreed last year that isolation mandates are a reserve measure to be used with caution in emergency circumstances [SWC-22-MIN-0118 refers]. Jurisdictions that took a similar approach to New Zealand in managing COVID-19 have since removed isolation mandates – for example, Australia in October 2022, and Singapore in February 2023.

   b. The effectiveness of an isolation mandate as opposed to guidance at this stage in the pandemic is unclear: the impact of removing the isolation mandate is unable to be modelled as there is limited data

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available in relation to several key assumptions, like existing compliance and how that might change. However, a direct comparison of hospital bed occupancy for COVID-19 cases per capita in Australian states that do not have an isolation mandate and New Zealand, cited in the previous PHRA, "suggests the difference in isolation policy is not impacting on bed occupancy" (although caution is expressed regarding this data).

c. Ending the isolation mandate would remove the current need to compensate employers for staff absences due to COVID-19: closing the Leave Support Scheme would result in fiscal savings of approximately $70 million. As the emergency phase of the COVID-19 response is over, staff absences are a normal risk that businesses should be expected to plan for, rather than having government bear those costs.

81. If the isolation mandate is retained, the Treasury recommends a shift to a test-to-release. Test-to-release was widely adopted by other countries (including Singapore) before their mandates were removed as a more proportionate approach to isolation. The modelling is clear that this is expected to have little impact on infections and hospitalisations but could have significant economic and social benefits.

Masks

82 Te Whatu Ora support establishing a managed pathway to remove mask mandates and the approach to normalise the use of masks in health service settings to protect against transmission of respiratory infections including COVID-19.

83 However, Te Whatu Ora strongly recommend the change does not occur until the end of winter 2023, at which point it can be reviewed relative to broad public health considerations and operational contexts. Te Whatu Ora frontline staff are strongly in favour of retaining the Mask Order through the current winter period as they would struggle to absorb even small impacts on hospital capacity. Te Whatu Ora also considers that there are limitations in the modelling about the level of impact that should be expected. Te Whatu Ora has noted that if there was to be a change to isolation, they would have further concerns around the removal of the Mask Order, as this provides a further layer of protection for vulnerable people in high-risk settings.

Consultation

84 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

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Whai Ora, Te Arawhiti, Te Puni Kōkiri, Te Whatu Ora, WorkSafe, the Treasury, Whaikaha – Ministry of Disabled People.

Financial Implications

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

Legislative Implications

86 The recommendations in this paper involve the following legislative implications:

86.1 if self-isolation shifts to a test-to-release model, the Self-isolation Order would need to be amended

86.2 if requirements for visitors to wear masks in health service settings are no longer appropriate, the Masks Order would need to be revoked.

87 The Ministry of Education has noted that if mandatory isolation was removed, changes would need to be made to regulations relating to licensing for early childhood education centres (3rd tier legislation). This would typically require two months' lead time, but this process can be expedited.

Impact Analysis

88 A Regulatory Impact Statement has been completed and is attached as Appendix Two. The Ministry of Health QA panel has reviewed the Impact Statement titled "Continuing with mandatory public health measures under the COVID-19 Public Health Response Act 2020", produced by the Ministry of Health and dated 13 June 2023. The panel considers that the Impact Statement Meets the quality assurance criteria.

89 The Impact Statement is clear, complete and consulted. The analysis is balanced in its presentation of the information and impacts are identified and assessed.

Human Rights

New Zealand Bill of Rights Act (Crown Law Office advice) *[legally privileged]*

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90 s 9(2)(h)

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91 s 9(2)(h)

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93.1 s 9(2)(h)

93.2 s 9(2)(h)

93.3 s 9(2)(h)

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s 9(2)(h)

93.4 s 9(2)(h)

93.5 s 9(2)(h)

94 s 9(2)(h)

95 s 9(2)(h)

96 s 9(2)(h)

Mask mandate

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97 s 9(2)(h) [redacted]

Communications

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

Next steps

99 If Cabinet agrees to revoke the Masks 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.

100 Unless there is a significant change in COVID-19 risk, the remaining self-isolation requirement will be reviewed again in August 2023. Manatū Hauora will report back to the Minister of Health on the results of that review, and to Cabinet if changes are proposed.

Proactive Release

101 This paper will be proactively released following Cabinet consideration.

Recommendations

The Minister of Health recommends that the Committee:

1 note that in April 2022, Cabinet agreed to retain the following mandatory COVID-19 public health measures [CAB-23-MIN-0136]:

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

1.2 masks for visitors to health services.

2 note that there is an authorisation under section 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, and masks for visitors to health care settings, until 30 June 2023;

3 note that the Prime Minister will receive advice on renewing the section 8(c) authorisation, as required, in the week beginning 19 June 2023;

Review of case isolation requirements

4 agree to:

EITHER

1.3 amend the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 to enable cases who test negative on a COVID-19 rapid antigen test on days 6 or 7 to leave isolation;

OR [recommended by the Director-General of Health]

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1.4 retain the status quo of 7-day mandatory self-isolation for COVID-19 cases;

5 note that a maximum lead time of two weeks would be required to ensure appropriate public communications can be developed, and operational pathways for supply of RATs are readied for the change;

6 agree to discontinue the provision of free RATs at airports to travellers arriving from overseas from 1 January 2024;

Review of government mandated mask requirements

7 agree to:

EITHER [recommended by the Director-General of Health]

7.1 revoke the COVID-19 Public Health Response (Masks) Order;

OR

7.2 retain the COVID-19 Public Health Response (Masks) Order;

8 note that a maximum lead time of two weeks would be required to ensure that health service providers have had sufficient time to review and update their infection protection and control policies;

Next steps

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

10. note that drafting instructions will be issued to Parliamentary Counsel Office to give effect to recommendations 4 and 7;

11. note that COVID-19 response settings will be reviewed again in August 2023.

Authorised for lodgement

Hon Dr Ayesha Verrall

Minister of Health

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

Appendix 2: Regulatory Impact Statement (attached)

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Regulatory Impact Statement: 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:* appropriate public health 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:	13 June 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 Minister of Health must have regard to the advice from the Director-General of Health (Director-General) about the risks of the outbreak or spread of COVID-19 and the appropriate measures to address those risks and be satisfied that the measures are appropriate to achieving the purpose of the COVID-19 Act and do not limit, or are a justified limit, on the rights and freedoms in the BORA.

Executive Summary

This Regulatory Impact Statement (RIS) sets out the review of the current public health regulatory settings 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), and the COVID-19 Public Health Response (Masks) Order 2022 (the Mask Order) both of which are made under the COVID-19 Act.

Self-isolation of cases

The Director-General recommended that either mandatory 7-day self-isolation for cases be retained or a 5-day test-to-release isolation regime is introduced. 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. Isolation remains more effective than other less restrictive measures, or a combination of less restrictive measures, such as face masks or physical distancing.

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 also suggests that adherence to guidance is typically much lower than to mandates. Removing mandatory isolation, therefore, could 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.

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Masks

The Director-General recommended that the Mask Order be removed and be replaced by infection prevention control (IPC) guidance. The current Mask 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 Mask Order will enable providers to create bespoke policies to best cater to their respective communities and the community risk at the time and support the transition to a more enduring approach to the use of masks as an ongoing infection prevention control measure.

Implementation, monitoring, and review

The settings recommended for self-isolation are already in place and would require no additional implementation if the status quo is retained. An amendment to the Self-Isolation Order and a communications plan would be needed to support any change to isolation settings. The removal of the Mask Order would require updated IPC guidance to include visitors to healthcare facilities. These measures remain under regular monitoring and review, including through regular Public Health Risk Assessments (PHRA).

Limitations and Constraints on Analysis

This proposal is subject to the following limitations:

- limited time to prepare this RIS following the PHRA
- 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.

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)

Jane Chambers

Group Manager, Public Health Policy and Regulation

Public Health Agency

Manatū Hauora

Quality Assurance (completed by QA panel)

Reviewing Agency:	Manatū Hauora
Panel Assessment & Comment:	The Ministry of Health QA panel has reviewed the Impact Statement titled “Public health measures under the COVID-19 Public Health Response Act 2020”, produced by the Ministry of Health and dated 13 June 2023. The panel considers that the Impact Statement meets the quality assurance criteria. The Impact Statement is clear, complete and consulted. The analysis is balanced in its presentation of the information and impacts are identified and assessed.

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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 – that 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.

The remaining mandatory measures are set out in COVID-19 orders, which may be made under the COVID-19 Public Health Response Act 2020 (the Act) only:

- while an epidemic notice under section 5 of the Epidemic Preparedness Act 2006 is in force for COVID-19, or
- while a state of emergency or transition period in respect of COVID-19 under the Civil Defence Emergency Management Act 2002 is in force, or
- if the Prime Minister has authorised the use of COVID-19 orders.

The Prime Minister has authorised the use of COVID-19 Orders until 30 June 2023. The Minister of Health must be satisfied that any order made under the Act is appropriate to achieving the purpose of the Act and does not limit, or is a justified limit on, the rights and freedoms in the New Zealand Bill of Rights Act 1993 (the BORA). In April 2023, the Minister of Health agreed to retain the following COVID-19 mandatory public health measures:

- 7-day self-isolation for cases; and
- mask requirements for visitors to healthcare services.

Under the New Zealand Bill of Rights Act 1990 (BORA) and the COVID-19 Public Health Response Act 2020 (the COVID-19 Act), the Minister of Health must have regard to the advice from the Director-General of Health (Director-General) about the risks of the outbreak or spread of COVID-19 and the appropriate measures to address those risks and be satisfied that the order is appropriate to achieving the purpose of the COVID-19 Act and does not limit, or is a justified limit, on the rights and freedoms in the BORA.

As COVID-19 orders are an emergency measure, used to respond to the risk of an outbreak or the spread of COVID-19, they must be regularly reviewed to ensure that they remain appropriate and justified.

How is the status quo expected to develop?

A Public Health Risk Assessment (PHRA) carried out on 22 May 2023 considered what public health measures are appropriate to address current risk posed by the COVID-19 outbreak. The PHRA was based on recent data about the progress of the pandemic, modelling of likely future developments, and on input from community sources. 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 since the last PHRA in March 2023 in most regions after increasing slightly in April 2023.

The hospital admission rate for COVID-19 decreased slightly since late April to a 7-day rolling average of 0.85 per 100,000 for the week ending 14 May 2023. There are some signs that different hospitalisation rates (including hospitalisations with as well as for COVID-19) by region may be a function of different testing practices in hospitals.

Age-adjusted admission risk ratios for Māori and Pacific peoples are more variable due to smaller numbers but remain generally higher compared to a European or Other baseline,

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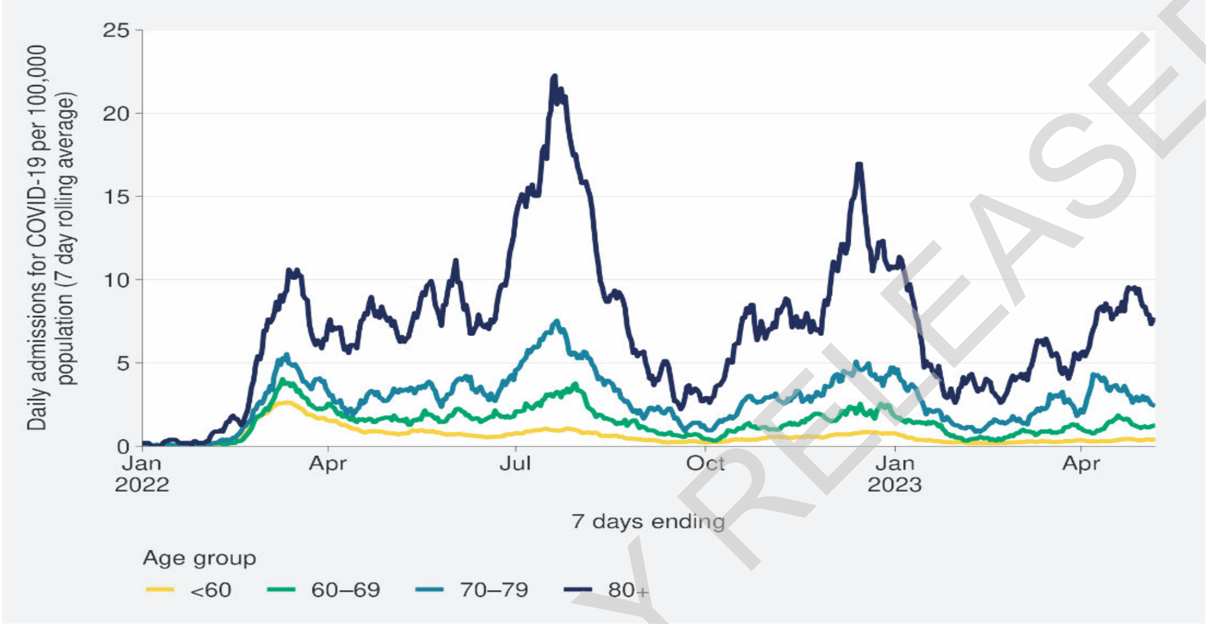
indicating a greater risk of hospital admission. The age-standardised admission rates for Māori and Pacific peoples continue to track above European and Other for age standardised admissions into April 2023.

On a population basis, people aged 80 or over have consistently had the highest hospital admission rate, as shown by Figure 2 below. From 1 January 2023 there have been 1087 hospital admissions in people aged 80 years or over.

Figure 1: Daily age standardised admissions for COVID-19 per 100,000 population (7 day rolling average) – by age group



The PHRA assessed the current risk to be low, relative to earlier periods of the epidemic, and the incidence of hospitalisations to have stabilised. The Director-General agreed with this assessment.

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.

Based on preliminary analysis, the practical choices that were considered at the 22 May 2023 PHRA were the following:

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Self-Isolation

- Retain the status quo of mandatory 7-day isolation for cases
  or
- Reduce mandatory isolation to 5 days and allow those who test negative on days 6 or 7 to be released from isolation, provided they no longer have symptoms

  or
- Reduce mandatory isolation to 5 days provided the case no longer has any symptoms but either require or recommend that cases not enter high-risk settings on days 6 and 7

  or
- Remove mandatory isolation for cases and move to guidance only for cases.

Masks

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

Discussion

Self-isolation for cases

Self-isolation of cases has been the cornerstone of New Zealand's public health response to COVID-19. It is simple and generally well-understood and 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.

Overseas evidence suggests that a legal requirement to self-isolate results in significantly greater adherence than a recommendation to self-isolate, although the difference in the effectiveness of the two approaches is probably reducing over time. 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 (85% in November 2022 and February 2023), 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).

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.

Reducing the period of self-isolation from 7 to 5-days and adding either a test-to-release requirement for days 6 and 7 or limitations on where cases could visit on those days (high-risk settings such as aged residential care facilities and hospitals) was also considered. While there may be some benefits of test-to-release from a theoretical perspective, in terms of reduced time in isolation, the potential benefits are modest (an estimated average reduction of time in isolation of 1.3 days), and the implementation challenges are significant in terms of changes to the legislative framework, and the development of communication materials and guidance for the public.

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Specifically, there are concerns that:

- partial change creates uncertainty for the public on when to isolate, and people might interpret the isolation period as having reduced to 5 days creating additional transmission risk;
- test to release adds complexity to public messaging – when the model was used for healthcare workers, extensive guidance was needed to explain the change;
- as the option relies on the ability for cases to access RATs in order to have the possibility of being released early, this option is reliant on the extent to which actual access to RATs is equitable;
- the approach may only result in marginal gain – based on data from Canterbury healthcare workers, approximately 1 in 15-20 workers were both asymptomatic and had a negative RAT at day 5;
- while the relaxing of settings may reduce the time spent in isolation it will increase the number of infectious people in the community, seeding further cases so the net effect will be lessened;
- in the context of winter and an expected increase in cases, any actions that increase transmission will also increase hospitalisations, placing further burden on the system.

Revoking the requirement to self-isolate and replacing it with new guidance was also considered. Modelling indicated this would lead to an increase in cases, hospitalisations and deaths over the other options considered and place an even greater strain on hospital resources over the winter period.

Masks for visitors to healthcare services

Mask mandates have been an important measure in ensuring high uptake 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 effective or required.

Removing the Mask 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. 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 aged residential care 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. Removing the Mask Order would allow healthcare providers to make mask policies consistent across their facilities and ensure IPC measures remain proportionate to the risks.

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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.

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.
  - The Ministry for Pacific Peoples reiterated previous feedback that Pacific peoples are a vulnerable group that continue to experience inequitable outcomes and noted that if tests do not remain free this would be an additional cost and potential barrier for low-income families including Pacific families.
  - Whaikaha noted that COVID-19 impacts continue to combine with and exacerbate existing barriers and inequities for disabled people and their whanāu.
  - Te Arawhiti supported the retention of the status quo for case isolation noting the disproportionate impact COVID-19 continues to have on Māori.
- 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. 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.

Public Health Risk Assessment

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:

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- **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.

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.

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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 use of COVID-19 orders is an emergency measure, and the Government must ensure that any use of COVID-19 orders is justified and proportionate to the risk of an outbreak or the spread of COVID-19
- In responding to the pandemic, 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.

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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.

Reduce restrictions - minimise the proportion of people who are subject to rights limiting restrictions

Te Tiriti - aligns with the active protection principle in Te Tiriti.

Protect the vulnerable - support ongoing protection of vulnerable populations

Reduce infection of high-risk persons - minimise the risk of hospitalisations or deaths of high-risk persons

Implementation and public communication - ease of implementation, including communicating any changes to the public.

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.

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1. Case self-isolation requirement

Counter-factual and proposal

Option 1	Option 2	Option 3	Option 4
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.	Reduce mandatory isolation to 5 days, and allow cases who test negative on days 6 or 7 to be released from isolation, provided they no longer have any symptoms.	Reduce mandatory isolation to 5 days provided the case no longer has any symptoms, but either mandate (option 3A) or provide guidance (option 3B) that cases not enter high-risk settings on days 6 and 7.	Revoke the requirement for cases to isolate, and instead provide guidance that cases isolate for 7 days.

Preferred Option	Retain the current requirement for mandatory 7-day self-isolation of cases. While the incidence of hospitalisations has stabilised, with winter approaching, a precautionary approach is appropriate.

Multi-criteria assessment

Table 1: Comparison of relative strengths and weaknesses of self-isolation options

	Reduce restrictions	***Te Tiriti***	***Protect the vulnerable***	***Reduce infection of high-risk people***	***Implementation and public communication***
Option 1: Retain the status quo 7-day mandatory isolation for cases	Low	High	High	High	High
Option 2: Reduce mandatory isolation to 5 days, and allow cases who test negative on days 6 or 7 to be released from isolation, provided they no longer have any symptoms	High	Medium	Medium	Medium	Medium
Option 3: Reduce mandatory isolation to 5 days provided the case no longer has any symptoms, but either mandate (option 3A) or provide guidance (option 3B) that cases not enter high-risk settings on days 6 and 7	High	Medium	Medium	Low	Low
Option 4: Revoke the requirement for cases to isolate, and instead provide guidance that cases isolate for 7 days	High	Low	Low	Low	High

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Note: All assessments are relative to the other options

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	Revoke the Masks Order and instead provide guidance to wear masks in health settings.

Preferred Option	Revoke the current visitor only face mask mandate in health service settings and replace with a national recommendation that all health service providers include mask requirements for visitors (along with all other persons) within their IPC policy.

Multi-criteria assessment

Table 2: Comparison of relative strengths and weaknesses of Mask options

	Reduce transmission	***Reduce restrictions***	***Protect the vulnerable***	***Implementation and public communication***	***Te Tiriti***
Option 1: Remove the Mask Order requiring visitors to healthcare settings to wear a face mask	**Medium**	**High**	**Medium**	**High**	**Medium**
Option 2: Retain the Mask Order requiring visitors to healthcare settings to wear a face mask	**High**	**Low**	**High**	**Low**	**High**

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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. 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 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.

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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 mask requirements for people accessing medical services, provides people with disabilities some 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 Mask 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 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

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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 Mask 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 Mask 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.

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 specific focus must be granted to achieving equitable outcomes for Māori. The report found that the Government was failing to meet Te Tiriti obligations, 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.

Ongoing 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 Whānau Ora Regional Leadership Groups. Measures targeted at Māori continue to be necessary but have not been sufficient 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 key to realising this duty. National Iwi Chairs Forum 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.

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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 7-day self-isolation for COVID-19 cases.
b) Remove mandatory face masks for visitors to healthcare services

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 Mask Order would require updated IPC guidance to include visitors to healthcare facilities. Manatū Hauora will work with Te Whatu Ora on developing and disseminating 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 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 August 2023.

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MANATŪ HAUORA
MINISTRY OF HEALTH

Memo

COVID-19 Public Health Risk Assessment

Date:	2 June 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,
From:	Dr Nicholas Jones, Director of Public Health, Public Health Agency Te Pou Hauora Tūmatanui
For your:	Information and Decision

Purpose of report

1. This memo provides my advice as Director of Public Health following the 22 May 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, conducted over the period from 22 May to 30 May, was to assess the current public health risk arising from COVID-19 in Aotearoa New Zealand.
3. Based on the PHRA wider committee's deliberations, I assess the overall public health risk as low and most likely to remain low over the next 6 weeks. While I have considered potential step-down measures, with winter approaching I am taking a precautionary approach and recommending the retention of mandatory case isolation for 7-days. However, I do recommend removing face mask requirements for visitors to healthcare settings and replacing this with guidance. The risk has shifted from COVID-19 prevention to a wider health system risk including influenza and other respiratory illnesses and warrants a shift from COVID-19 emergency measures to the introduction of facility policies for visitor mask use.
4. While not directly relevant to the assessment of proportionality, I have received advice from the COVID TAG that risks from influenza and other respiratory illnesses are likely to be increasing during this period. The TAG expressed a strong view that approaches to COVID-19 management that will also help to manage influenza risk should be prioritised.

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Face masks

Current requirement	The COVID-19 Public Health Response (Masks) Order 2022 ('the Mask Order') 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 visitor only face mask mandate in health service settings **Replace** with a national recommendation that all health service providers include mask requirements for visitors (along with all other persons) within their IPC policy. I would also recommend that Government healthcare facilities adopt the requirements for visitors to their settings to wear masks. Provider policies should provide for the total well-being of residents in Aged Residential Care whose need for contact with asymptomatic unmasked whanau members may outweigh risks in private spaces. **Note** that masks remain an important tool to prevent the transmission of COVID-19 and other respiratory pathogens. The current Mask Order is providing limited protection from the transmission of communicable diseases. The recommendation to revoke this mandate is to encourage a more holistic and sustainable approach to mask usage in high-risk settings.

Case isolation

Current requirement	The COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 ('the Self-Isolation Order') requires all people who test positive for COVID-19 to isolate for 7 days. Mandatory 7-day self-isolation of COVID-19 cases.
Director of Public Health recommendation	**Retain** the current requirement. **Note** that while the incidence of hospitalisations has stabilised, with winter approaching I am taking a precautionary approach and recommending the retention of mandatory case isolation for 7-days. **Note** that if the mandate is reduced or removed, cases would still be provided with guidance to isolate. Such guidance could include: • avoid contact with older people or others at higher risk of severe illness in other settings • if they must leave isolation – use a well-fitted mask, and avoid crowded places • let their school or employer know

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	• stay home until no longer experiencing any symptoms of acute respiratory infection.

Recommendations

It is recommended that you:

1.	Note	the key indicators currently suggest overall COVID-19 public health risk is low	Noted
2.	Agree	to recommend to the Minister of Health in relation to the COVID-19 Public Health Response (Masks) Order 2022: **Option 1: Remove the Mask Order** requiring visitors to healthcare settings to wear a face mask *(Director of Public Health recommended option);* OR **Option 2 Retain the Mask Order** requiring visitors to healthcare settings to wear a face mask.	Yes/No Yes/No
3.	Agree	to recommend to the Minister of Health in relation to the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022: **Option 1: Retain the status quo** 7-day mandatory isolation for cases *(Director of Public Health recommended option)*; OR **Option 2: Test to release** – amend the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 to enable cases to be released from isolation on days 6 or 7 if they undertake a rapid antigen test and get a negative result *(Director of Public Health recommended option if option 1 is not selected)*; OR **Option 3:** Amend the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 to **require cases to isolate for 5 days** and **EITHER:** a. **Option 3A – mandate for cases not to enter high-risk settings** on days 6 and 7); OR	Yes/No Yes/No Yes/No

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		b. **Option 3B – guidance for cases not to enter high-risk settings** on days 6 and 7; OR	Yes/No
		Option 4: Revoke the requirement for cases to isolate – and instead provide guidance recommending that cases isolate for 7 days	Yes/No
4.	Agree	to recommend to the Minister of Health that if options 3A or 3B are selected, high risk settings be defined as hospitals, aged residential care facilities, other residential care, and prisons	Yes/No
5.	Agree	to recommend to the Minister of Health that if options 2, 3A, or 3B are selected, the period for self-isolation in the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 begins on the earlier of either: • symptoms – from one day after onset of symptoms, or • positive COVID-19 test – from day of positive COVID-19 test.	Yes/No
6.	Note	COVID-19 booster vaccination uptake has been low, especially in high-risk populations	Noted
7.	Agree	to recommend to the Minister of Health that Manatū Hauora work with the Ministry of Business, Innovation, and Employment to update Manatū Hauora ventilation guidance to include practical actions that can be taken to monitor and improve ventilation in indoor settings (such as homes and public places)	Yes/No

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8.	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

Signature Date: 7 June 2023
Dr Nicholas Jones
Director of Public Health

Signature ____ Date: 8 June 2023
Dr Diana Sarfati
Director-General of Health | Te Tumu Whakarae mō te Hauora
Manatū Hauora | Ministry of Health

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Background

1. The COVID-19 Public Health Response Act 2020 requires that the Minister of Health (the Minister) keep COVID-19 Orders under regular review. There are currently two Orders that need to be reviewed:

    a. the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022, requiring positive cases of COVID-19 to isolate for 7 days.

    b. the COVID-19 Public Health Response (Masks) Order 2022, requiring visitors to health care settings wear a face mask

5. 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.

6. A subgroup of the committee met on 22 May with wider input provided from the full committee for comment between 25 – 29 May 2023. The PHRA also reviewed current orders in the context of current risk and considered whether the orders remain proportionate to risk and required to achieve equity objectives. I have also consulted the COVID-19 Technical Advisory Group prior to the PHRA Committee meeting. A meeting with COVID Modelling Aotearoa was held on 23 May 2023. This meeting was to discuss in more detail the modelling report provided to Manatū Hauora. A meeting with committee members from Te Aka Whai Ora was also held on 30 May 2023.

Current context

7. Through previous PHRAs we have assessed what the status of the COVID-19 outbreak is, how effective the Government's measures have been, and assessed if they are still proportionate to the risk. Key considerations have been the risk of new variants, the effects of COVID-19 on vulnerable populations, and the wider capability of the health system.

8. Data indicates the outbreak is stabilising. If current patterns continue, the epidemiology of the virus may not result in more serious threats. This might mean the mandatory requirements can be removed without serious adverse consequences by the end of winter 2023.

9. Relatedly, the Prime Minister has asked for separate advice on the "pathway for complete removal of restrictions".

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MINISTRY OF HEALTH

10. The World Health Organisation has recently announced that it considers that the emergency phase of the COVID-19 pandemic is over. This announcement, along with the Prime Minister's request, signals the need for further change to our COVID-19 response. As the risk has changed over the pandemic, the mix of measures has also changed with most restrictions having been removed progressively already.

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

11. 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 since the last PHRA in March 2023 in most regions after increasing slightly in April 2023.

12. The 7-day rolling average for new cases for the week ending 21 May 2023 was 1,891.[1] This is an increase from 1,672 in the week ending 14 May 2023. Case counts are increasingly likely to underestimate actual infections and caution should be applied in interpreting small fluctuations in the 7-day rolling average.

13. The hospital admission rate for COVID-19 decreased slightly since late April to a 7-day rolling average of 0.85 per 100,000 for the week ending 14 May 2023. There are some signs that different hospitalisation rates (including hospitalisations **with** as well as **for** COVID-19) by region may be a function of different testing practices in hospitals.

14. Age-adjusted admission risk ratios for Māori and Pacific peoples are more variable due to smaller numbers but remain generally higher compared to a European or Other baseline, indicating an ongoing greater risk of hospital admission. The age-standardised admission rates for Māori and Pacific peoples continue to track above European and Other for age standardised admissions into April 2023.

15. On a population basis, people aged 80 or over have consistently had the highest hospital admission rate, as shown by Figure 2 below. From 1 January 2023 there have been 1087 hospital admissions in people aged 80 years or over.

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[1] https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-current-cases

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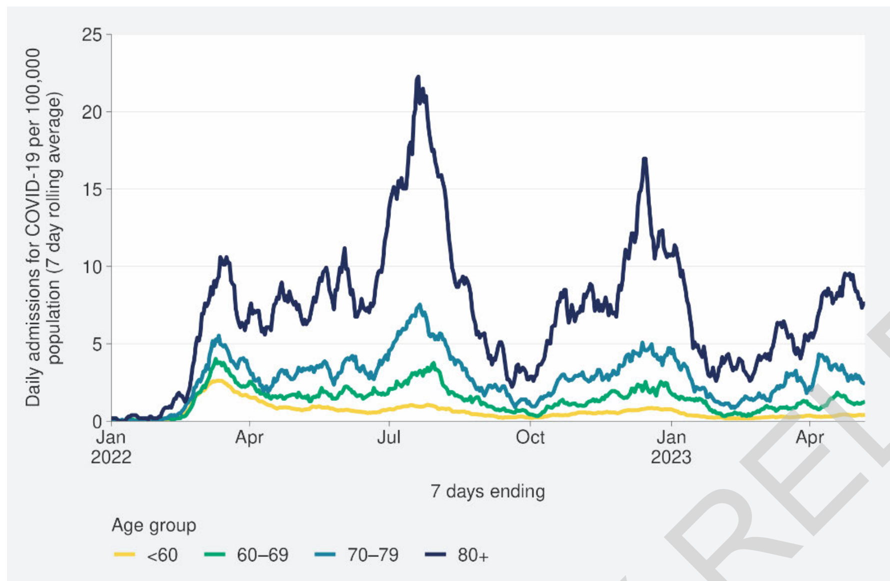
Figure 1: Daily admissions for COVID-19 per 100,000 population (7 day rolling average) – by age group



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16. Uptake of the COVID-19 booster vaccinations has slowed down. As of 28 May 2023, primary boosters' uptake was 73% with 39 % of the eligible population having had a 2nd booster. In high-risk populations the uptake is concerning with only 56% of eligible Māori having received a booster dose and 33% having received their second booster. The numbers are also low among Pacific Peoples with 61% of the eligible population having received a booster and 26% receiving both boosters.

17. At this point in the epidemic the total number of boosters is less important than the duration since the most recent booster with the greatest protection against hospitalisation or death coming from a booster within 6 months of infection regardless of the number of previous boosters. The concept of "up to date" reflects this idea where vaccination with dose 1 and 2 plus a booster within the last 6 months is probably a better marker of protection. Recovery from infection during the last six months also contributes to current protection. These factors make it difficult to estimate the percentage of the high-risk population currently optimally protected but it is likely that a high proportion of the population who have received only one booster would not be "up to date". COVID-19 immunisation coverage in high-risk populations may improve in the short term as a consequence of a campaign currently underway although I note that this campaign is not focused entirely on COVID-19 vaccination.[2]

18. XBB.1.16 has continued its growth, and is now the most common subvariant in New Zealand (24% of cases). This variant shows the strongest rate in current conditions and is expected to

[2] https://www.tewhatuora.govt.nz/about-us/news-and-updates/nationwide-immunisation-week-aims-to-boost-our-community-immunity/

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continue to rise in frequency. FK.1.1 continues to circulate (20% of sequenced cases) as do the formerly dominant XBB.1.5 (16%) and other XBB lineages (combined for 24%)

19. Having reviewed the status of the COVID-19 epidemic in New Zealand, I consider the current risk to be low relative to other periods of the epidemic and the incidence of hospitalisations to have stabilised. I note that elderly, especially those over 80 remain at the highest risk of mortality from COVID-19 with elderly Māori and Pacific peoples being at a higher risk.

Considerations for the decision making in this PHRA

20. Within this context, there are several factors that I have considered when making my recommendations.

Are the legal tests met to maintain the use of mandatory measures

21. This is the key consideration. The use of mandatory measures must be appropriate and proportionate to the outbreak risk. s 9(2)(h)

Continuing to protect vulnerable populations

22. The retention of the two remaining restrictions – case isolation and masking – underpin the objective of protecting people at higher risk of severe illness (ie, older people, Māori and Pacific peoples, disabled and immune compromised individuals, among other high-risk groups).

23. This issue is a key concern for several members of the Committee.

Mitigating the impact of winter illnesses

24. During the last PHRA, the recommendations were based on an early winter stress on the health system. As we move into winter and concern grows about the potential impact winter illnesses could have on the health system, the focus of the measures, individually and as a package, is to reduce COVID-19 related hospitalisations that increase total hospitalisation demand and thus adversely impact health service outcomes more generally.

Consistency with previous decisions

25. Following the last PHRA on 16 March 2023 I recommended:

    a. **retaining** the Self-Isolation Order

    b. **revoking** the Mask Order

    c. **revoking** the COVID-19 Public Health Response (Point-of-care Tests) Order 2021

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26. You agreed with my advice and sent to the Minister for her consideration. After consultation with Cabinet the Minister agreed to retain the Self-Isolation and Mask Orders, and revoke the Point of Care Testing Order.
27. In a stabilising outbreak environment, it is important our advice remains consistent if there are no significant developments. Additionally, it also presents an opportunity to consider options to step-down or remove existing measures if it is practical to do so.

The effectiveness of other non-mandatory measures

28. Masking for visitors in healthcare settings and case isolation remain as the last remaining mandatory measures. We are now reaching a point in the outbreak where we need to consider whether these remain as mandatory measures. As well as the outbreak context, we would need to consider whether any changes or improvements to existing non-mandatory measures are required to create a more enduring approach to mitigating risk following the removal or reduction of non-mandatory measures.

Review of the Orders under the COVID-19 Public Health Response Act 2020

Self-Isolation Order

Current requirement and previous advice

29. Under the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 ('the Order'), people who test positive for COVID-19 are required to isolate for 7 days from the earlier of the date their symptoms began, or the date they tested positive. Neither testing for COVID-19 upon the occurrence of symptoms nor reporting of results are required under the Order.
30. Isolation requirements have been reduced over the course of the pandemic from an initial 14 days to 10 days and then to the current 7-day requirement. The Director-General has previously provided advice that 7 days is considered the minimum threshold for self-isolation of symptomatic cases to remain an effective intervention. 5-day isolation is considered less effective, as many people may still be infectious on release at day 5. The infectivity of cases may be changing over time with hybrid immunity increasing within the population. Infectivity is not a binary phenomenon with even those remaining infectious at day 5 generally being less infectious than they would have been at day 1 or 2.
31. More recent evidence concerning symptom onset, period of infectivity and RAT test positivity suggests there are delays between these periods. In particular, there is likely to be 1 to 2 days between the commencement of infectivity and test positivity. This means there is an argument for linking isolation periods to either test positivity or a set period following symptom onset.

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32. Throughout the COVID-19 response, requirements in relation to COVID-19 mandated measures have balanced a desire to adequately manage risk, with a desire to ensure that measures are able to be easily communicated, understood, and acted upon by the public. The need for simplicity in messaging may mitigate against a change in isolation period start time.

Option 1: Retain the status quo 7-day mandatory isolation for cases (Director of Public Health recommended option)

33. The main advantage of this option is that it minimises the number of people who will be infectious on release from isolation. Based on estimates provided by COVID-19 Modelling Aotearoa (CMA), approximately 19% of people will be infectious on release following 7 days isolation [95%CI 13% - 25%].

34. Case isolation has been one of the cornerstone measures of New Zealand's public health response to COVID-19. This measure limits transmission of COVID-19 by reducing the proportion of infectious people having contact with and infecting others in the community, including vulnerable populations. There is evidence that people are more likely to isolate if required to, than if recommended to although the difference in the effectiveness of the two approaches is probably reducing over time. Removal of the mandate would lead to more infectious cases in the community, increasing overall infection rates, serious illness, hospitalisations, and death.

35. A further benefit of this option is that the requirement is simple and generally well-understood. It provides maximum protection independently of immunisation levels that are highly likely to be less than adequate to prevent inequitable hospitalisation risk for Māori and Pacific populations.

36. 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 (85% in November 2022 and February 2023), 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).

37. The main disadvantage of this option is that a number of cases will remain in isolation for longer than is necessary to protect those at higher risk from infection (i.e. when they are no longer infectious).

Option 2: Reduce mandatory isolation to 5 days, and allow cases who test negative on days 6 or 7 to be released from isolation, provided they no longer have any symptoms

38. The main advantage of this option is that it would enable a subset of people who are less likely to be infectious to be released 1 or 2 days earlier from isolation than they would under

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the status quo. Based on an estimate provided by CMA, ~22% of people would still be infectious on release under this option [95% CI, 16% - 30%].

39. It should be noted that the difference between the proportion likely to be infectious following a negative test on day 5 and the proportion leaving isolation after 7 days is not statistically significant. COVID-19 Modelling Aotearoa has stated that the number of additional cases likely to occur with the scenario would be insignificant, but concerns have been raised that the model assumptions may not account for ethnicity specific differences such as household composition. Estimates are also population wide rather than ethnicity specific.

40. It should also be noted that the modelling relies on an assumption that people will test and behave in accordance with the result (in terms of whether they remain in isolation or leave isolation). A key concern is that people might interpret this change as a move to 5-day isolation, which would mean a greater proportion of infectious people being released than has been estimated.

41. Test to release policies entail a number of parameters that can be varied in terms of what is required to exit isolation. The most common parameters are the number of negative RATs that are required; the minimum and/or maximum number of days of isolation that the person must complete; and whether the person is also required to be asymptomatic on release.

42. In New Zealand, test to return (a variation on test to release) has been used as part of the healthcare worker return to work programme since March 2022. This has allowed healthcare workers to return to work from day 5 if they are asymptomatic, feel well and have had two negative RATs. Extensive guidance was developed to ensure this pathway was well understood and to protect the wellbeing of affected staff members.[3] However, this mechanism did not result in a large increase in the available workforce. For example, at Canterbury DHB so few healthcare workers were both asymptomatic and tested negative (estimated to be 1 in 15-20 healthcare workers) that they stopped trying to utilise an early release pathway.

How would it be implemented

43. A negative RAT towards the end of an infection is a reasonable predictor that the person is unlikely to be infectious:

    a. while use of RATs early in an infection may miss some cases (because the person's viral load might *not yet* be at a level that they are likely to infect others), RATs are a good predictor of infectiousness for people towards the end of their infectious stage (days 5-10)

[3] https://www.tewhatuora.govt.nz/for-the-health-sector/covid-19-information-for-health-professionals/covid-19-information-for-all-health-professionals/guidance-for-critical-health-services-during-an-omicron-outbreak/

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b. being asymptomatic is not a good predictor of infectiousness on its own – while studies have tended to support greater transmission from symptomatic cases, the results are mixed and asymptomatic transmission, particularly early in the infection, is well documented.[4]

44. As outlined above, RATs are useful predictors of infectiousness, but if an individual is actively symptomatic (eg coughing and sneezing), this increases the likelihood of transmission, and therefore the potential risk. For this reason, test to release policies typically include a requirement that the individual is asymptomatic on release, in addition to having a negative RAT.

45. If test to release was considered in Aotearoa New Zealand, our advice is that it should include requirements for both a negative RAT and an absence of acute symptoms. This is consistent with current advice that states: "If you are still sick at the end of your self-isolation period, stay home until you are well and for 24 hours after you no longer have symptoms".[5]

46. Shifting to this option would reflect a step-down in mandatory COVID-19 measures, an intent signalled by the Prime Minister in April 2023.[6] In this context, it may be beneficial in that it could:

   a. help to prepare the public for a future scenario where there are no mandates in place – for example, a person may feel less inclined to leave isolation knowing that they are infectious (if they have done a RAT and it is still positive), than they might be if the guidance remained to isolate for 7 days. In that sense, it may help to give people the information that could help them to be aware of the risk they may present to others if leave isolation while still testing positive.

   b. help to prepare employers for the possibility that some may find it useful (and for certain settings it will be advisable) to require employees to test negative on a RAT before returning to work.

Would it work in practice?

47. The main disadvantage of this approach is that while there may be some benefits of test to release from a theoretical perspective, in terms of reduced time in isolation, the approach is not currently recommended as the potential benefits are modest (an estimated average reduction of time in isolation of 1.3 days), and the implementation challenges significant in terms of changes to the legislative framework, and the development of communication materials and guidance for the public. Further, the misinterpretation of any changes (such as reduced compliance with isolation) could increase transmission risk beyond that modelled.

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[4] https://www.gov.uk/government/publications/covid-19-omicron-variant-infectious-period-and-asymptomatic-and-symptomatic-transmission
[5] https://covid19.govt.nz/testing-and-isolation/if-you-have-covid-19/#finish-your-self-isolation
[6] https://www.beehive.govt.nz/sites/default/files/2023-04/Press%20Conference%2011%20April%202023.pdf

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48. Specifically, there are concerns that:
    a. partial change creates uncertainty for the public on when to isolate, and people might interpret the isolation period as having reduced to 5 days creating additional transmission risk
    b. test to release adds complexity to public messaging – when the model was used for healthcare workers, very extensive guidance was developed to explain the change
    c. as the option relies on the ability for cases to access RATs in order to have the *possibility* of being released early, this option is reliant on extent to which actual access to RATs is equitable
    d. the approach may only result in marginal gain – based on data from Canterbury healthcare workers, approximately 1 in 15-20 workers were both asymptomatic and had a negative RAT at day 5
    e. while the relaxing of settings may reduce the time spent in isolation it will increase the number of infectious people in the community, seeding further cases so the net effect will be lessened
    f. in the context of winter and an expected increase in cases, any actions that increase transmission will also increase hospitalisations, placing further burden on the system.

Option 3: Reduce mandatory isolation to 5 days provided the case no longer has any symptoms, but either mandate (option 3A) or provide guidance (option 3B) that cases not enter high-risk settings on days 6 and 7

49. The main advantage of this option is that it would enable cases to be released from isolation two days earlier, provided they no longer have any symptoms. Based on an estimate provided by CMA, approximately 36% of people would still be infectious on release on completion of 5 days isolation with no test to release (compared to 19% under the status quo).

50. In recognising that this option would result in a higher proportion of people being infectious on release, this option also seeks to mitigate the risk of onward transmission by either requiring or providing guidance that cases do not enter settings where a high proportion of people are likely to be at risk of severe disease.

51. I use the term “high-risk settings” in the sense of settings in which there are likely to be relatively large numbers of persons at risk of hospitalisation if infected. I would not include settings such as small enclosed indoor spaces that might be occupied by the general public. While such settings pose a higher risk of transmission, the proportion of persons at higher risk of hospitalisation if infected would be expected to be no greater than the general population.

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52. High risk settings for either option 3A or 3B are defined as: hospitals, aged residential care facilities, other residential care (eg disability), and prisons. Agencies provided suggestions for expanding this group:

    a. Whaikaha recommends that it could include (but is not limited to) vocational service (day centre) settings and specialist schools, but could also include events where there is a high-risk of transmission, eg funerals, tangihanga and weddings.

    b. Te Whatu Ora supports the recommendation to mandate cases not to enter high-risk settings in day 6 and 7. However they recommend that the list of high-risk settings should also include "schools and Early Childhood Education (ECE) centres where prolonged periods of contact in indoor spaces makes transmission of COVID-19 very likely. It is important that we reduce the risk of transmission in these settings to minimise the impact on children's education and minimise community spread".

53. I do not agree with the extension to schools or ECEs as while these might represent higher transmission risk they are not settings in which I would expect a high proportion of persons at risk of hospitalisation to be present.

54. The main disadvantage of these options is that while it restricts or provides guidance against entering settings where there are likely to be may people at risk of severe disease if they were infected, there is still a large number of people who are at risk of severe disease who are not in these settings.

55. s 9(2)(h)

56. s 9(2)(h)

Option 4: Revoke the requirement for cases to isolate, and instead provide guidance that cases isolate for 7 days

57. The main advantage of this option is that it would fulfil the intent for a step-down from mandatory measures.

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58. The main disadvantage is that it would likely lead to an increase in cases, hospitalisations, and deaths. Based on modelling provided by CMA in May 2023, in short-term (7-week period):

    a. No mandate with low compliance with guidance – is modelled to lead to between 259 deaths (95% CI 133-405) under an assumption of no seasonality, and 470 deaths (95%CI 264-710) under an assumption of strong seasonality.

    b. No mandate with high compliance with guidance – is modelled to lead to between 248 (95% CI 127-387) under an assumption of no seasonality, and 448 (95%CI 249-678) under an assumption of strong seasonality.

59. By contrast, scenarios based on mandates were modelled to lead to lower numbers of deaths.

    a. Mandate for 5-day isolation with no test to release – is modelled to lead to between 238 deaths (95% CI 123-368) under an assumption of no seasonality, and 427 deaths (95%CI 240-642) under an assumption of strong seasonality.

    b. Mandate for 5-day isolation with test to release – is modelled to lead to between 232 deaths (95% CI 122-358) under an assumption of no seasonality, and 418 deaths (95%CI 237-624) under an assumption of strong seasonality.

    c. Mandate for 7-day isolation (status quo) – is modelled to lead to between 232 deaths (95% CI 122-357) under an assumption of no seasonality, and 418 deaths (95%CI 237-622) under an assumption of strong seasonality.

60. Further, the removal of the isolation mandate will likely also trigger a removal of the leave support scheme, which will likely result in lower compliance with any guidance (in addition to that modelled). Based on data provided by the Ministry of Social Development, in April 2023 approximately one in three cases accessed the scheme.

Modelling provided by COVID-19 Modelling Aotearoa on the case isolation options

61. CMA has provided updated modelling on the impact of a range of scenarios on cases, hospitalisations, and mortality – both in the short term (7 weeks from 15 May) and longer term (26 weeks from 15 May). In addition, CMA provided results under three different assumptions regarding the possible impact of winter – no seasonality, weak seasonality, and strong seasonality. This has resulted in ranges that are wider than previously modelled.

62. Overall, the modelling results indicate:

    a. **There is still a high degree of uncertainty around how key indicators will track over both the short and longer term.** Modelling simply provides a range of possible outcomes based on different assumptions and inputs. For example, peak bed occupancy over the 26-week period ranges from 280 (95%CI 180 - 410) for the 7-day mandatory isolation under an assumption of no seasonality, through to 740 (95%CI 440 – 1,040) for

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no mandate and low compliance with guidance, and high seasonality. It should be noted that evidence of seasonality for COVID-19 is still weak.

b. **Modelling of scenarios based on guidance results in considerably higher level of infections, hospitalisations, deaths, and peak hospital occupancy in the short-term than scenarios based on mandates**. As an example, using an assumption of weak seasonality, this leads to between 525,000 and 587,000 infections in the short-term for guidance scenarios, compared to between 439,000 and 472,000 infections under mandate scenarios.

c. As outlined in the paragraph 54, the **extent to which transmission increases over winter is a key variable** – and generally affects results to a greater extent than which scenario is chosen.

63. Preliminary analysis of the potential impact by ethnicity by applying population proportions to date to the CMA modelling output (using an assumption of weak seasonality) suggests that in the short term (7-week period):

a. no mandate with low compliance with guidance: 535 hospitalisations for Māori, and 365 hospitalisations for Pacific Peoples

b. no mandate with high compliance with guidance: 484 hospitalisations for Māori, and 330 hospitalisations for Pacific Peoples

c. 7-day mandatory isolation (status quo): 424 hospitalisations for Māori, and 289 hospitalisations for Pacific Peoples.

d. It is important to note that modelling scenarios by ethnicity do not account for differences in household size, multigenerational household composition and differential access to care in Māori and Pacific Communities. Therefore, it is likely that the scenarios above under-estimate the magnitude of impact from change in isolation policy.

Trigger for starting isolation timing

64. Current isolation policy has the 'isolation clock' starting from the earlier of first day of symptoms or a positive RAT – this day is considered 'day 0', with isolation ending following completion of 'day 7'.[7] However, it is possible that this incentivises cases to report symptoms prior to their first positive test to shorten their effective isolation period.

65. Adjusting the 'isolation clock' to start from the day of first positive test instead would reduce the proportion of cases still infectious after isolation and help improve the effectiveness of the isolation policy. According to modelling scenarios, this would mean that a cases 'isolation clock' starts on average 1.6 days later.

[7] https://covid19.govt.nz/testing-and-isolation/if-you-have-covid-19/#start-your-7-days-of-self-isolation

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66. s 9(2)(h)

Comparison of options

67. The epidemiological context relevant to consideration of the Self-Isolation Order includes:

   a. The health system is experiencing high demand that is likely to increase during winter and thus isolation may help to reduce any additional burden on the health system and its ability to deliver care.

   b. 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.

   c. While the majority of people who develop COVID-19 fully recover, the WHO estimates that approximately 10–20% of people experience a variety of mid and long-term effects after they recover from their initial illness.[8]

   d. 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. Based on deaths reported for the period from 1 January to 28 May 2023, if the number of deaths attributable to COVID-19 (437) continues at the current rate, this would result in approximately 1,078 annual deaths. This would potentially place it as the sixth most common cause of death – between chronic obstructive pulmonary disease (1,156 deaths in 2020), and bowel cancer (883 deaths in 2020). A study that estimated influenza-associated mortality in New Zealand over the period 1990–2008 found that seasonal influenza was associated with an average of 401 medical deaths annually.[9]

68. When considering changes to the self-isolation order, the key criteria are the degree to which the various options:

   a. **reduce hospitalisation or death due to infection high risk persons** – isolation impacts this by reducing the chances of an infectious person coming in to contact with a high risk person

   b. **reduce unnecessary restrictions** - minimise the proportion of people who are required to isolate when not infectious

[8] https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-(covid-19)-post-covid-19-condition

[9] Kessaram T, Stanley J, Baker MG. Estimating influenza-associated mortality in New Zealand from 1990 to 2008. Influenza Other Respir Viruses. 2015 Jan;9(1):14-9. doi: 10.1111/irv.12292. Epub 2014 Oct 24. PMID: 25346370; PMCID: PMC4280813.

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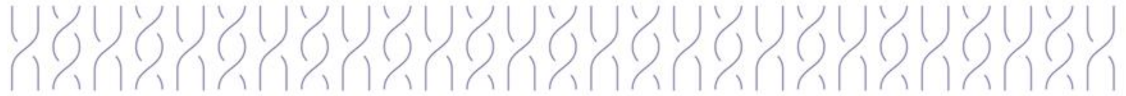

c. **protect the vulnerable** - support ongoing protection of vulnerable populations

d. **implementation and public communication** - ease of implementation, including communicating any changes to the public.

e. **Te Tiriti** - aligns with the active protection principle in Te Tiriti.

69. Table 1 below provides a high-level comparison of the relative strengths and weaknesses of each of the options.

Table 1: Comparison of relative strengths and weaknesses of self-isolation options

	Reduce infection of high-risk persons	***Reduce unnecessary restrictions***	***Protect the vulnerable***	***Implementation and public communication***	***Te Tiriti***
Option 1: Retain the status quo 7-day mandatory isolation for cases (Director of Public Health recommended option)	**High** 19% infectious on release	**Medium**	**High**	**High**	**High**
Option 2: Reduce mandatory isolation to 5 days, and allow cases who test negative on days 6 or 7 to be released from isolation, provided they no longer have any symptoms	**Medium** 22% infectious on release	**High**	**Medium**	**Medium**	**Medium**
Option 3: Reduce mandatory isolation to 5 days provided the case no longer has any symptoms, but either mandate (option 3A) or provide guidance (option 3B) that cases not enter high-risk settings on days 6 and 7	**Medium** 36% infectious on release after 5 days (impact mitigated by guidance or mandate re high-risk settings)	**Medium**	**Medium**	**Low**	**Medium**
Option 4: Revoke the requirement for cases to isolate, and instead provide guidance that cases isolate for 7 days	**Low**	**NA**	**Low**	**High**	**Low**

Note: All assessments are relative to the other options

Views of other agencies

70. Whaikaha supports the retention of the status quo 7-day mandatory isolation period. The rationale for this position is that "the current settings are a pivotal measure to protect disabled people from COVID-19 exposure, as well as key workforce groups that disabled people receive support from (e.g the disability sector workforce, and the health workforce)". See Appendix 3 for feedback from Whaikaha.

71. Feedback from Te Whatu Ora (see appendix 4) includes:

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a. acknowledgement the importance of reviewing and where appropriate removing rights-limiting restrictions when these actions are no longer proportionate to the risk posed by COVID-19

b. support for establishing a managed pathway to remove mask mandates and the approach to normalise the use of masks in health service settings to protect against transmission of respiratory infections including COVID-19

c. however, Te Whatu Ora also "strongly recommend(s) the change does not occur until the end of winter 2023, at which point it can be reviewed relative to broad public health considerations and operational contexts. Our frontline workforce is strongly in favour of retaining the Mask Order through the current winter period on the basis that we would struggle to absorb even small impacts on hospital capacity and that there are limitations in the modelling about the level of impact we can expect."

d. caution against significant change at this point: "making changes now, when we expect the remaining COVID-19 restrictions to be removed post-winter, is likely to create confusion for the public, our health system settings, be costly and take significant time and money to update. This would include regions and providers developing or amending guidance over multiple products, at their busiest time of the year".

Director of Public Health view

72. I support retaining the requirement for COVID-19 cases to isolate for 7 days, as this:

a. takes a precautionary approach, given the upcoming winter period, and that booster uptake remains relatively low

b. aligns most closely with the active protection principle in Te Tiriti

c. does not rely on improving booster immunisation coverage to achieve equity.

Considerations if the requirement to isolate is not maintained

73. Regardless of the recommendations in the public health advice the Director-General of Health will provide to the Minister, 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 does not support the recommendations.

74. If this occurs, there is a need to ensure that there is a smooth transition to a new approach. There is also a set of actions that could be undertaken to mitigate the effects of removing the mandate. Appendix 6 contains my recommendations if the isolation mandate is removed, in line with the proposed Aotearoa New Zealand Strategic Framework for Managing COVID-19, which will be considered by Cabinet in late June at the same time as the Cabinet paper on COVID-19 measures.

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75. I note the achieving equity in booster vaccination coverage would provide assurance that mandate removal was considerably less likely to lead to further inequity of outcomes.

Mask Order

Current requirement and previous advice

76. Under the Mask Order, 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). 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).

77. Face masks are proven to reduce the spread of COVID-19 and have been an important measure in mitigating the effects of COVID-19 throughout the response.

78. The Mask Order initially covered a wider range of settings such as supermarkets and public transport however as the COVID-19 pandemic has stabilised this has been narrowed to now only include Healthcare settings.

79. At the last PHRA on 16 March 2023, I recommended that the Mask Order could be revoked provided sufficient guidance and support was provided to healthcare services.

Option 1: Remove the Mask Order requiring visitors to healthcare settings to wear a face mask (Director of Public Health recommended option)

80. The current Mask Order covers a broad range of environments, and masks are not always optimal for every setting. The main advantage of this option is it would allow for healthcare settings to create their own bespoke settings most appropriate for their community.

81. The Mask Order is also a COVID-19 specific emergency order, and strong guidance would allow for other issues to be considered when implementing mask policies, such as:

    a. the spread of other communicable diseases

    b. the pressure on the wider health system

    c. other mitigation measures in place to reduce the spread of disease such as social distancing and ventilation.

82. The Mask Order currently requires only visitors to wear masks, specifically excluding staff and patients. Moving to national guidance could allow for more flexible mask policy consistent across staff, patients, and visitors. It would also enable the guidance to change based where in a facility you are. For example, masks may be mandatory for visitor and patient in a General Practice waiting room but not in the consultation room.

83. The main disadvantage of this option is the risk that removing the Mask Order will see a drop in compliance as happened when public transport was removed from the Mask Order in

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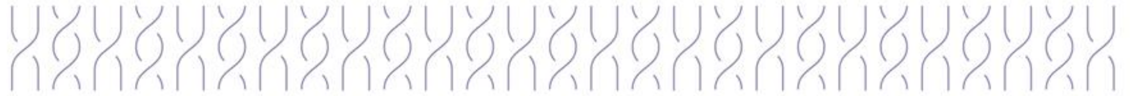

September 2022. The Mask Order while broad, sets a high minimum standard for mask use in high-risk settings. Before removing the Order there would need to be clear guidance issues on what good mask practise looks like, and an emphasis that masks remain an important mitigation tool for preventing transmission of respiratory illnesses.

Option 2: Retain the Mask Order requiring visitors to healthcare settings to wear a face mask

84. The main advantage of this option is to continue consistent messaging about the importance of wearing face masks, especially in healthcare settings which have a series of characteristics that elevate the risk of transmission and/or the risk of severe disease. These settings and the services provided within these settings typically:

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

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

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

   d. People with hospital-acquired COVID-19 infections are more likely to have poorer outcomes than community-acquired infections.[10] Feedback from 2 districts in late 2022 noted possible links between visitors and hospital-acquired cases of COVID-19.

85. There are, however, issues with how the Mask Order is implemented across the health sector:

   a. It applies across almost all health settings regardless of the risk or use of the healthcare setting

   b. The Mask Order only applies to visitors creating an inconsistency between staff, patients and visitors in who is required to wear a mask

   c. Compliance to the Mask Order varies drastically between different settings, with enforcement being left to each individual provider.

Comparison of options

86. When considering whether to renew the Mask Order, we must consider if the Order is still effective, proportionate and if there are other measures that could offer the same protection. the key criteria are:

[10] In Victoria, Australia, 7.6% of hospital-acquired infections resulted in death, compared to 0.14% of reported cases in the general population in the same period. This shows that infections in hospital settings are associated with significantly (over 50-fold) higher mortality. Victoria Department of Health. 2022. Chief Health Officer Advice to Premier, 29 August 2022. https://www.health.vic.gov.au/publications/chief-health-officer-advice-to-premier

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a. **reduce transmission** to high-risk persons - minimise the spread of COVID-19 in healthcare settings
b. **reduce unnecessary restrictions** - minimise any unnecessary restrictions on individuals in healthcare settings
c. **protect the vulnerable** - support ongoing protection of vulnerable populations
d. **implementation and public communication** - ease of implementation, including communicating any changes to the public.
e. **Te Tiriti** - aligns with the active protection principle in Te Tiriti.

Table 2: Comparison of relative strengths and weaknesses of Mask options

	Reduce transmission	***Reduce unnecessary restrictions***	***Protect the vulnerable***	***Implementation and public communication***	***Te Tiriti***
Option 1: Remove the Mask Order requiring visitors to healthcare settings to wear a face mask (Director of Public Health recommended option)	**Medium**	**High**	**Medium**	**High**	**Medium**
Option 2: Retain the Mask Order requiring visitors to healthcare settings to wear a face mask	**High**	**Low**	**High**	**Low**	**High**

Note: All assessments are relative to the other options

Views of other agencies

87. Whaikaha supports the retention of the Mask Order. Disabled adults are less likely to report being in good health than non-disabled adults (62.6% and 90.8%, respectively - 2021/22: New Zealand Health Survey). A decision to remove masks in healthcare setting may discourage disabled people to access the health supports they require. See Appendix 3 for feedback from Whaikaha.
88. Te Whatu Ora supports retention of the Mask Order until the end of winter. Their primary concern is about removing measures during winter on the basis they would struggle to absorb even small impacts on hospital capacity and that there are limitations in the modelling about the level of impact we can expect. See Appendix 4 for feedback from Te Whatu Ora.

Director of Public Health view

89. I support revoking the Order requiring visitors to wear masks in healthcare settings
90. There is a need to normalise the use of masks in health service settings to protect against transmission of respiratory infections including COVID-19. Keeping the spread of illness in healthcare settings is not just a COVID-19 issue. Replacing an order dependent on emergency powers with organisational policy will support the transition to a more enduring approach to the use of masks as an ongoing infection prevention control measure. This approach will also

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enable mask requirements to be modified according to risk in a way that does not require a Ministerial or Cabinet decision.

91. Noting my recommendation to remove the Mask Order, it is important to emphasise masks are still a vital part of our COVID-19 response. The Government should continue to strongly recommend their use in high-risk settings especially over winter when influenza and other viruses such as RSV are typically prevalent and ensure they are accessible to those in healthcare settings.

New Zealand Bill of Rights Act (Crown Law Office advice) [legally privileged]

s 9(2)(h)

92. s 9(2)(h)

93. s 9(2)(h)

94. s 9(2)(h)

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95. s 9(2)(h)

   a. s 9(2)(h)

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Priorities going forward

103. The Government still has a range of non-mandatory measures it can utilise to reduce the spread and effect of COVID-19. Many of the measures in place such as the leave support scheme and distribution of masks in high-risk settings have been crucial in reducing the spread of COVID-19 and supporting vulnerable communities.

Vaccination

104. The initial COVID-19 vaccine roll out was successful with 89.3% of the population over 12 years receiving a primary course. This high level of immunisation has been one of the key protections from COVID-19 and ensuring there is a resilient public.

105. The subsequent COVID-19 booster vaccinations uptake needs to be a priority over winter. As noted in Paragraph 16 COVID-19 booster uptake remains low, especially among high-risk populations. A targeted approach to the Māori and Pacific communities is necessary with both groups also more likely to be hospitalised and die from COVID-19. Continued focus and investment in outreach, holistic, whānau-centred approaches and Māori provider and community-led solutions is required for measures to be equitable and effective. Further steps in prioritising sentinel sites for vaccination in areas that specifically target Māori and Pacific communities.

106. The disabled community remains disproportionately affected by COVID-19 in terms of hospitalisations mortality and in how they must adjust their behaviour to avoid COVID-19. We also know the disabled community face a range of issues accessing healthcare including vaccinations. For these reasons the disabled community also need to be prioritised in the vaccination campaign.

107. There is evidence that residents of Aged Residential Facilities are at the highest risk of hospitalisation or death from COVID-19. This may be because of both age, levels of frailty and the higher risk of transmission in ARC settings. This group in my view should be prioritised for booster vaccination with specific interventions to achieve the highest possible coverage for COVID-19 along with Influenza vaccination.

Access to masks

108. Masks remain a key measure in protecting against COVID-19 and other communicable diseases. With my recommendation of the removing the Mask Order it is important that we continue to support good mask use in high-risk settings. Providing masks to those entering healthcare settings remains an important measure in reducing further hospitalisation from COVID-19 and other communicable diseases.

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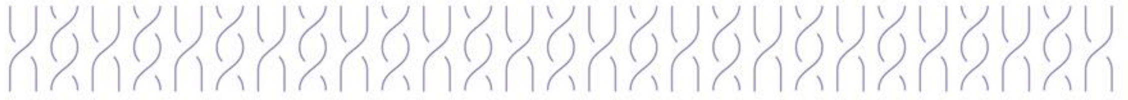

Ventilation

109. It is now well understood that SARS-CoV-2 (the virus that leads to COVID-19 infection) is largely transmitted via the air, and that most infection occurs in indoor settings.

110. Improving ventilation, particularly in higher risk indoor settings, is one way to reduce risk of transmission. For both passive and mechanical ventilation systems, it is generally possible to improve ventilation by using simple measures without making structural changes to those systems. There are several different techniques that can be used to measure the effectiveness of ventilation.

111. Over the past 6-12 months there have been a series of international developments in relation to improving ventilation, including recently updated practical guidance from the US Centers for Disease Control and Prevention (CDC).[11]

Progress to date

112. The two areas that have had the most experience to date in using ventilation to reduce risk of transmission are education (state schools), and managed isolation and quarantine (MIQ).

113. More recent developments include:
    a. The opportunity to consider ventilation in a broader range of settings beyond education was also identified in the recently published COVID-19 Winter Surge Package Rapid Review.[12]
    b. In May 2023, Greater Wellington Regional Council wrote to Manatū Hauora requesting health advice on CO_2 levels on buses, attaching a copy of a study they had commissioned on CO_2 levels on Metlink buses at different times and under different conditions.

114. This and previous PHRAs support the need to strengthen effective public health measures that do not involve limitations on individual rights as part of a process of stepping back from emergency mandates.

115. In response to the above context, I recommend that Manatū Hauora work with the Ministry of Business, Innovation and Employment to update Manatū Hauora ventilation guidance to include practical actions that can be taken to monitor and improve ventilation, building on earlier joint work.

Equity and Te Tiriti o Waitangi considerations for maintaining measures

116. 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

[11] https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html
[12] https://www.health.govt.nz/system/files/documents/publications/rapid_review_of_covid-19_winter_surge_package_final_report_jr.pdf

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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.

Impact of COVID-19 on vulnerable populations

117. Pacific peoples and Māori continue to be disproportionately impacted by COVID-19. Both groups have significantly higher hospitalisation and mortality rates compared to other ethnicities, after standardising by age. Further there remain key systemic barriers for these groups accessing equitable health care including for COVID-19.

118. Disabled people are also disproportionately affected by the COVID-19 outbreak. From 1 January 2022 to 16 November 2022 data showed disabled people on Disability Support Services (DSS) have a hospitalisation risk that is 4.2 times higher than the rest of the population. Further, rates of COVID-19 attributed mortality are 13 times higher among this group compared to the rest of the population.

119. Throughout the pandemic we have also seen age be a significant risk factor in hospitalisation and mortality rates from COVID-19. We also know that many elderly people alter their lifestyles to keep safe from COVID-19.

Equity considerations in these recommendations

120. There is an ongoing and strong concern from Whaikaha and Te Aka Whai Ora 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.

121. 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. Whaikaha and Te Aka Whai Ora have also 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.

122. Subsequently, the recommendation to revoke the Mask Order is accompanied by updated Te Whatu Ora infection prevention and control (IPC) guidance to empower stakeholders in the health sector to manage the risk levels relevant to their premises and roles.

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123. Vaccination remains one of the key measures in our response and helps communities build resilience to COVID-19 outbreaks. Considering the low uptake of COVID-19 boosters in Māori and Pacific communities it is important that this outreach is prioritised, to reduce the future impacts of COVID-19 on these communities.

124. 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.

125. Further measures such as the leave support scheme continue to support communities and reduce the impact of taking time off work for COVID-19. In April 2023, 13,269 applications were approved for a total of $12.2 million paid out.

126. 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.

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

End.

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Appendix 1 Intelligence, Surveillance & Knowledge PHRA update

Appendix 2 Information pack to support PHRA assessment

Appendix 3 Feedback from Whaikaha

COVID-19 Public Health Risk Assessment (draft)
Isolation requirements

- We note that this paper recommends a mandatory 5-day isolation, supported by a complementary mandate for cases to not enter high-risk settings. The high-risk settings are proposed to include hospitals, aged residential care facilities, other residential care facilities (eg. disability), and prisons.
    - International evidence has shown that people with learning disability are at particularly at-risk of adverse COVID-19 outcomes.
    - Further consideration should be given to whether a more broad definition of high-risk settings are needed to protect at-risk population. This could include (but is not limited to) vocational service (day centre) settings and specialist schools, but could also include events where there is a high-risk of transmission, eg funerals, tangihanga and weddings.
- Whaikaha supports retention of the current 7-day self-isolation period, rather than a change to 5-day isolation. The current settings are a pivotal measure to protect disabled people from COVID-19 exposure, as well as key workforce groups that disabled people receive support from (e.g the disability sector workforce, and the health workforce).
    - Any changes to the current settings would need to be supported by robust communication, including bespoke information for the disability community, and the workforce who supports disabled people.
    - Disabled people and their whānau have repeatedly described a lack of clear and concise official communications targeted to disabled people and their whānau, in response to COVID-19. Ensuring clear and accessible information designed for disabled people and their whānau will help avoid stress and information disparity.

Face Masks

- Whaikaha supports retaining the status quo. Masks continue to be seen as an important protective measure to stop the spread of COVID-19. Some disability community members have noted that a face mask can also show others that a person/their whānau may be at greater risk of COVID-19. The community also recognises that continuing mask wearing is also important to help prevent the spread of other diseases.
- Disabled adults are less likely to report being in good health than non-disabled adults (62.6% and 90.8%, respectively - 2021/22: New Zealand Health Survey). A decision to remove masks in healthcare setting may discourage disabled people to access the health supports they require.

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- We note that a variable approach to masking will be difficult to communicate eg individual service providers' requirements may vary, and could result in information gaps for disabled people who rely on information in alternate formats (e.g. New Zealand Sign Language, Easy Read, large print, audio and Braille).
- Disabled people who receive DSS often rely on personal cares in confined indoor spaces, with close and sustained interactions with carers. Given the added risk for this group, combined with co-morbidity factors, particular consideration of this context will be needed for the development of Infection, Prevention and Control guidance for the disability workforce.
- Whaikaha shares the same concerns raised by the Pharmacy and Hospital and Specialist Services sectors, regarding the need to protect at-risk populations and the workforce, particularly during the winter illness period. There is a risk that these changes could create further pressures on the health and disability sector workforces, who are continually short-staffed.
    - While we note the Allied Health sector has shared a view that the continuation of the current Mask Order would see non-compliance grow, Whaikaha is concerned that the proposed change to the mask requirements would see non-compliance grow further than it would with the current settings, particular in light of other jurisdictions' experiences.
    - We also note that recent feedback from carers organisations' raises that case numbers remain high from their perspective, and that there is a need for targeted communications on booking COVID-19 and other winter illness vaccinations.

General comments

- Throughout this paper, we would recommend referring to disabled people whenever highlighting population groups who are at greater risk of severe illness/COVID-19 risk, or priority groups. For example, reference could be made in paragraphs 8, 19, and 25.
- The actions listed under paragraph 40 could be strengthened by including reference to the need to develop bespoke, accessible communications for the disability community. The disability community and associate workforce has highlighted several areas where communications could be strengthened, and repeatedly reinforced, in relation to protection and precautions. This includes:
    - How disabled people and their families can continue to take protective measures.
    - Continued messaging for the general public around safe behaviours to keep at-risk people safe eg the importance of social distancing (while in public and for health and disability workers who provide supports for disabled people).
    - Guidance on ventilation – including how people can ventilate their own homes during winter (particularly important for people who receive personal cares in their homes).
    - How to prepare for COVID-19, including getting pre-prepared prescriptions for antivirals for quicker access.

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- There are other opportunities to strengthen the response to ensure the disability community is protected for COVID-19 (in addition to what has already been included in the information pack). For example:
    - Paragraph 51 states that a targeted approach to [vaccinations for] the Māori and Pacific communities is necessary with both groups also more likely to be hospitalised and die from COVID-19. Continued focus and investment in outreach, holistic, whānau-centred approaches and Māori provider and community-led solutions is required for measures to be equitable and effective. It is important these approaches reach intersectional communities within these population groups, including tāngata whaikaha Māori and Pacific disabled people.
    - Also noting that disabled people are at greater risk of COVID-19, we would recommend consideration of bespoke vaccination approaches for the disability community.

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Appendix 4 Feedback from Te Whatu Ora

Te Whatu Ora
Health New Zealand

Memo

Outbreak Response feedback on PHRA recommendations for Mask and Isolation settings

To	Dr Nicholas Jones, Director of Public Health, Public Health Agency, Manatū Hauora	Tracking No.	N/A
From	Matt Hannant, Interim Director Outbreak Response, National Public Health Service Te Whatu Ora	Date	29/05/2023

Contact for telephone discussion (if required)			
Name	Position	Telephone	1st contact
Matt Hannant	Interim Director, Outbreak Response, NPHS	s 9(2)(a)	X

Purpose

1. This memo provides feedback from Outbreak Response, Te Whatu Ora, on the draft of the Public Health Risk Assessment (PHRA) with initial recommendations from the Director of Public Health. Feedback includes operational implications and further considerations.

Background

2. A public health risk assessment was carried out by the Public Health Agency on 22 May 2023 to review the appropriateness of COVID-19 settings. Manatū Hauora have asked us for feedback on the Public Health Risk Assessment memo with the initial recommendations for the Director-General of Health (Director-General).
3. This new process for the PHRA did not provide an opportunity for Te Whatu Ora (including NPHS) to review or discuss proposed changes, or to seek additional information.
4. On Thursday on 25 May 2023, your team sought our feedback on the memo of advice to the Director General of Health and sought operational implications of the advice for the National Public Health Service.
5. Reflecting the short window of opportunity provided noting information is to be back to your office by midday Tuesday 30 May 2023, we have collated the below and attached.
6. Our feedback is focused on the operational implications to our national public health services and settings, including the timing of any changes and alignment with the 'pathway for complete removal of restrictions', the impact on the health system and health workforce during winter, and the likely disproportionate impact on vulnerable populations.
7. We have also provided detailed and specific comments directly into the draft memo to the Director-General for your considered reference and response.
8. On 26 April 2023 we provided the Public Health Agency with advice on the operational impacts for Test to Release policies and removal of mask mandates. The information provided remains accurate and should be read in conjunction with this memo.

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9. We note there will also be a further opportunity to provide feedback on the draft Cabinet paper on COVID-19 measures in early June, prior to the paper being lodged for the SWC meeting on 21 June and Cabinet on 29 June.

Summary of recommendations

10. The draft PHRA memo of 25 May 2023 recommends:
    a) to revoke the current COVID-19 Public Health Response (Masks) Order 2022 ('the Mask Order') and replace this with a national recommendation that all health service providers include mask requirements for visitors (along with all other persons) within their Infection Prevention and Control (IPC) policy. It is noted the guideline should state that each policy should include a requirement for all visitors to wear masks during winter months or at other times when there is an elevated risk of transmission as defined by local infection control leaders or by the Director of Public Health.
    b) that the Self-Isolation Order is amended to reduce mandatory case isolation from 7 days to 5 days and mandate cases not to enter high-risk settings on days 6 and 7 noting that several options were provided including the option to retain the current settings.

Feedback on the recommendations

11. The Prime Minister has requested advice on the "pathway for complete removal of restrictions". The PHRA recommendations could more clearly explain the relationship with this advice particularly delineating a request for information versus a request for advice. Notably, Te Whatu Ora National Public Health Service has not sighted this request formally.
12. Making changes now, when we expect the remaining COVID-19 restrictions to be removed post-winter, is likely to create confusion for the public, our health system settings, be costly and take significant time and money to update. This would include regions and providers developing or amending guidance over multiple products, at their busiest time of the year.

Masks

13. We acknowledge the importance of reviewing and where appropriate removing rights-limiting restrictions when these actions are no longer proportionate to the risk posed by COVID-19. We support establishing a managed pathway to remove mask mandates and the approach to normalise the use of masks in health service settings to protect against transmission of respiratory infections including COVID-19.
14. However, we strongly recommend the change does not occur until the end of winter 2023, at which point it can be reviewed relative to broad public health considerations and operational contexts. Our frontline workforce is strongly in favour of retaining the Mask Order through the current winter period on the basis that we would struggle to absorb even small impacts on hospital capacity and that there are limitations in the modelling about the level of impact we can expect.
15. The workforce has noted that the Mask Order supports their efforts to maximise visitor compliance with mask wearing and are concerned that the same result would not be achieved with organisational policies alone.
16. A transition period that takes us past winter would support the provision of consistent and clear communications for the health and disability system and public and enable a managed transition with national IPC guidance that can be adapted at a local level. Asking the health and disability system to devote additional time and resource at this

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time would be a significant administrative and implementation burden for a workforce that is already under considerable pressure and constraint. We estimate it would take at least 4-6 weeks to develop and implement national IPC guidance.

17. Further based on all evidence and information by other health agencies, there does not appear to be sufficient justification in the draft PHRA memo for suggesting this change at this time, given that there has not been a significant change in the overall public health risk since advice was previously provided to the Director-General and Cabinet.
18. We would encourage health agencies collectively to further consider the impacts of making incremental changes to strategies and public messaging, noting the findings and recommendations in the Allen and Clarke Winter Surge Review.
19. We note that concerns have been raised for vulnerable populations at disproportionate risk, and there is limited action taken to address the concerns/risks. We consider that acknowledging these concerns but not taking appropriate steps to address these concerns goes against our obligations under Te Tiriti o Waitangi and the Pae Ora (Healthy Futures) Act 2022.
20. There is high quality evidence to support the benefits of mask use at preventing transmission of respiratory infections. Where medical masks only are used, masks are more effective as source control (i.e., they protect the infected person from spreading the virus to others) than at protecting the wearer from infection.
21. Our hospitals and residential healthcare settings are populated with our oldest, and most medically vulnerable. Patients, residents, and staff are dependent on the policies and protocols that are put in place to provide safe environments and due consultation is required to ensure changes to policies incorporate consumer voice.
22. There is variation in the type of ventilation systems across health sector settings and as such some sectors such as aged care may be at a disadvantage if ventilation systems are old or ineffective. It should also be noted that ventilation alone does not protect from transmission in face -to -face interactions.

Isolation

23. We acknowledge the importance in reviewing and where appropriate removing rights-limiting restrictions when these actions are no longer proportionate to the risk posed by COVID-19.
24. We strongly encourage the PHRA recommendations to align with the "pathway for complete removal of restrictions" and caution against multiple changes to isolation requirements and the potential confusion for the public.
25. We are concerned about the potential impacts of reducing the isolation period to 5 days as we move into the winter period and note the feedback from Whaikaha and Te Aka Whai Ora about the community level impacts of projected increased transmission.
26. We note that the proposed change to reduce isolation to 5 days is projected to almost double the proportion of people that will exit isolation while still infectious (from 19% to 36%). We also note that the modelling suggests an (unquantified) increase in hospital admissions. These impacts will fall disproportionately on our most vulnerable population at a time of high seasonal illness and constrained health care settings.
27. We have reservations about the potential impact at this time and should this change be adopted; we consider there is an amplified need to retain the Mask Order to minimise the risk of in-hospital transmission of COVID-19 and other respiratory-borne pathogens. There are practical challenges for screening and enforcing day 6 and 7 visitor exclusion from high-risk settings. In practice it would likely be a high trust model and rely on individual adherence, supported by communications and collateral.

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28. There has been stability in isolation requirements since phase 3 of the Omicron response. A change to isolation requirements would be a large operational change to manage, one recently reflected on and communicated to Ministers as part of the transitional plan for COVID-19 funding and operations. Once clarity has been achieved on the parameters of the change and the secondary impacts to initiatives, changes would need to be made across technology platforms, training for telehealth providers, and updates to guidance documents for the public and the health and disability sector. We estimate that a lead-time of at least 4-6 weeks is required at minimum.
29. There are financial risks and implications when introducing change as part of the COVID-19 Health System Response.
30. We support the recommendation to mandate cases not to enter high-risk settings in day 6 and 7. However the list of high-risk settings should also include schools and Early Childhood Education (ECE) centres where prolonged periods of contact in indoor spaces makes transmission of COVID-19 very likely. It is important that we reduce the risk of transmission in these settings to minimise the impact on children's education and minimise community spread.
31. Operationally, we would anticipate more reflection of the concerns raised previously with your teams and greater alignment to broader work ongoing across the COVID-19 Strategic Framework, the transitional planning for COVID-19 Health System Response, the Winter Wellness programme and reflection of settings on the "two campaign" approach for the COVID-19 Vaccine.

Matt Hannant
Interim Director
Outbreak Response
National Public Health Service

31 / 05 / 2023

Appendix 5 Feedback from Te Aka Whai Ora

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MANATŪ HAUORA
MINISTRY OF HEALTH

Appendix 6 Recommended measures if the isolation mandate is revoked

Prepare	1.	**Maintain surveillance capability and public reporting** – this covers a range of activity including wastewater surveillance in community and at airports for infection trends and genomic information (which can be leveraged for other pathogens in the future); genomic surveillance of clinical cases; in hospitals and at GP clinics; syndromic surveillance (eg flutracker), to monitor patterns in COVID-19 and other respiratory diseases; laboratory data to monitor admissions and GP clinic visits for COVID-19 as well as influenza, RSV and other pathogens; international monitoring of data and horizon scanning; partnerships with international organisations eg CDNA, WHO.
	2.	**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.
	3.	**Strengthen effective public health measures that do not involve limitations on individual rights** – for example, updating health guidance on practical ways to monitor and improve ventilation.
	4.	**Continue to provide public communications** – to encourage people to test and ensure they are up to date on vaccinations.
Manage	5.	**Provide clear guidance for cases** – including that they should isolate for a minimum of 5 days and until they no longer have any symptoms of acute respiratory infection. Additional guidance would be provided – for example, to avoid contact with older people or others at higher risks of severe illness in other settings, to let their school or employer know, and if they must unavoidably leave isolation – use a well-fitted mask, and avoid crowded places**.** This would also include advice that cases may be directed to isolate by a Medical Officer of Health should a failure to isolate place vulnerable persons at risk.
	6.	**Provide guidance on mask use** – for health service settings, and more generally.
	7.	**Provide guidance for high-risk workplaces and priority settings** – covering return to work, and best practice approaches to reduce risk. The Ministry of Education has indicated that licensing criteria for early learning services would need to be updated to specify an exclusion period for COVID-19, alongside other infectious conditions (3rd tier legislation).
	8.	**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.
	9.	**Keep eligibility criteria under review** - for vaccinations, and treatments (including antivirals).
Integrate	10.	Transition **funding** of COVID-19 vaccines and treatments to the Combined Pharmaceutical Budget (CPB) (H2023024109 refers).

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