MANATŪ HAUORA
MINISTRY OF HEALTH

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

28 October 2022

s 9(2)(a)

By email: s 9(2)(a)
Ref: H2022013681

Tēnā koe s 9(2)(a)

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act), which was transferred from the Department of the Prime Minister and Cabinet (DPMC) to Manatū Hauora (the Ministry of Health) on 29 September 2022 for information regarding the extension of special powers under an Epidemic Notice. You requested:

> *"Epidemic Preparedness (COVID-19) Notice 2020 Renewal Notice (No 3) 2022. https://gazette.govt.nz/assets/pdf-cache/2022/2022-sl3849.pdf?2022-09-13_09%3A54%3A58=*
> *This Gazette notice dated 12th day of September 2022, extends the March 24, 2020 notice (the principal notice) here: https://gazette.govt.nz/assets/pdf-cache/2020/2020-go1368.pdf?2020-12-17_22%3A55%3A25=*
> *In Gazette notice you state that you are:*
> *'satisfied that the effects of the outbreak of COVID-19 are likely to continue to disrupt essential governmental and business activity in New Zealand significantly'*
> *The Ministry of Health states: 'An Epidemic Notice is a public policy tool to help Government agencies respond swiftly and effectively in a rapidly evolving situation. An epidemic notice enables the use of a number of 'special powers' in legislation.'*
> *Please supply all evidence you relied on, and the reasons for your decision in extending the powers put in place March 24, 2020."*

The briefing titled *Review of the Epidemic Preparedness (COVID-19) Notice 2020* has been identified within scope of your request. A copy of this document is appended to this letter with some information withheld under the following sections of the Act:

- section 9(2)(a), to protect the privacy of natural persons;
- section 9(2)(g)(i), to maintain the effective conduct of public affairs through the free and frank expression of opinions;
- section 9(2)(h), to maintain legal professional privilege.

I have considered the countervailing public interest in release in making this decision and consider that it does not outweigh the need to withhold at this time.

I trust this information fulfils your request. Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Manatū Hauora website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

Steve Waldegrave
Associate Deputy Director-General
Strategy Policy and Legislation | Te Pou Rautaki

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Review of the Epidemic Preparedness (COVID-19) Notice 2020

Date due to MO:	8 September 2022	**Action required by:**	9 September 2022
Security level:	IN CONFIDENCE	**Health Report number:**	20221306
To:	Rt Hon Jacinda Ardern, Prime Minister Hon Andrew Little, Minister of Health Hon Dr Ayesha Verrall, Minister for COVID 19 Response		

Contact for telephone discussion

Name	Position	Telephone
Dr Diana Sarfati	Director General of Health Te Tumu Whakarae mō te Hauora	S9(2)(a)
Maree Roberts	Deputy Director-General, Strategy, Policy and Legislation	S9(2)(a)

Minister's office to complete:

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

Comment:

Review of the Epidemic Preparedness (COVID-19) Notice 2020

Security level:	IN CONFIDENCE	**Date:**	8 September 2022
To:	Rt Hon Jacinda Ardern, Prime Minister Hon Andrew Little, Minister of Health Hon Dr Ayesha Verrall, Minister for COVID-19 Response		

Purpose of report

1. This report recommends that the Epidemic Preparedness (COVID-19) Notice 2020 be renewed for 5 weeks, until 20 October 2022.

Summary

2. The current Epidemic Preparedness (COVID-19) Notice 2020 (Epidemic Notice) is due to expire on 16 September 2022. Action is required by the Prime Minister to renew the notice by 9 September 2022.

3. The Epidemic Notice currently enables COVID-19 orders to be made under the COVID-19 Public Health Response Act 2020, and epidemic management notices, and immediate modification orders to be made under the Epidemic Preparedness Act 2006. It also allows certain provisions within other primary legislation.

4. The Epidemic Notice can only be renewed if the Prime Minister is satisfied that the effects of an outbreak of COVID-19 are likely to continue to disrupt essential governmental and business activity in New Zealand (or stated part of New Zealand) significantly.

5. While the prevalence of COVID-19 in the community has fallen from peaks earlier this year, there remains a level of unpredictability about the progress of the pandemic. The number of cases and hospitalisations due to COVID-19 is expected to continue to change in ways that cannot always be accurately predicted through modelling, particularly if changes are made to the public health measures which, have to date, contributed to the reduction in the number of cases and hospitalisations.

6. I consider that in the absence of the public health measures recommended to Cabinet, significant disruption to health services and other essential services is likely.

7. On this basis, as a precautionary approach, I recommend that the Epidemic Notice be renewed for 5 weeks, to 20 October 2022. A public health risk assessment is planned for around 6 October 2022, which will provide the basis for further advice to Ministers in mid-October on whether public health measures relying on orders under the COVID-19 Public Health Response Act 2020 continue to be proportionate and justified beyond this time.

8. I recommend that the Prime Minister sign the Epidemic Preparedness (COVID-19) Notice 2020 Renewal Notice (No 3) 2022 by 9 September 2022.

Recommendations

I recommend you:

a) **Note** that the Epidemic Preparedness (COVID-19) Notice 2020 (Epidemic Notice) is due to expire on 16 September 2022.

b) **Note** that the Epidemic Notice enables powers under the COVID-19 Public Health Response Act 2020, the Health Act 1956, the Epidemic Preparedness Act 2006, and enables provisions in other primary legislation.

c) **Note** that in the absence of the public health measures recommended to Cabinet, significant disruption to health services and other essential services is likely.

d) **Note** that I have recommended the retention of the following public health requirements:

   (i) 7-day self-isolation for cases

   (ii) air travellers to New Zealand to provide information for contact tracing purposes prior to departure

   (iii) masks for visitors in healthcare settings including primary care, urgent care, hospitals, aged residential care, and disability care.

e) **Agree**, as the Minister of Health, that the Epidemic Notice is renewed for 5 weeks until 20 October 2022. **Yes/No**

f) **Agree**, as the Minister for COVID-19 Response, that the Epidemic Notice is renewed for 5 weeks until 20 October 2022. **Yes/No**

g) **Refer** a copy of this report to, and consult with, the Deputy Prime Minister, Minister of Justice and any other Minister as required **Yes/No**

h) **Agree**, as the Prime Minister, that the Epidemic Notice be renewed for 5 weeks until 20 October 2022: **Yes/No**

   (i) having considered the written recommendation of the Director-General of Health; and

   (ii) being satisfied that the effects of the outbreak concerned are likely to continue to disrupt essential government and business activity in New Zealand significantly.

i) **Note** that a public health risk assessment is planned to be undertaken on or around 6 October 2022, which will provide the basis for further advice to Ministers in mid-October on whether public health measures relying on orders under the COVID-19 Public Health Response Act 2020 continue to be justified beyond this time.

j) **Note** that the renewal of the Epidemic Notice will take effect upon publication in the Gazette and expire on 20 October 2022, unless earlier renewed or revoked.

k) **Note** that after the renewal of the Epidemic Notice is signed, a copy of that renewal must be presented as soon as possible to Parliament.

Dr Diana Sarfati
Te Tumu Whakarae mō te Hauora
Director-General of Health
Date: 08 / 09 / 2022

Hon Dr Ayesha Verrall
Minister for COVID-19 Response
Date:

Hon Andrew Little
Minister of Health
Date:

Rt Hon Jacinda Ardern
Prime Minister
Date: 12 / 9 / 22

Review of the Epidemic Preparedness (COVID-19) Notice 2020

Epidemic Notice decision

9. The Epidemic Preparedness (COVID-19) 2020 (the Epidemic Notice) is due to expire on 16 September 2022. The notice was made on 24 March 2020 and has been renewed 9 times, after considering the written recommendation of the Director-General of Health (Director-General) and with agreement from the Minister of Health and the Minister for COVID-19 Response.

10. An Epidemic Notice is made under section 5, and renewed under section 7, of the Epidemic Preparedness Act 2006. To do this, the Prime Minister, with the agreement of the Minister of Health, and upon recommendation from the Director-General, must be satisfied that the effects of an outbreak of a quarantinable disease[1] are **likely to continue to disrupt essential governmental and business activity in New Zealand (or parts of New Zealand) significantly.**

11. An Epidemic Notice will expire on the earliest of the following:

    a. the day 3 months after its commencement

    b. a date stated in the notice

    c. a day stated for the purpose by the Prime Minister by further notice, such as a 5-week renewal period recommended in this paper.

Powers and instruments dependent on the Epidemic Notice

12. The Epidemic Notice currently enables a range of powers and instruments including:

    a. orders made under the COVID-19 Public Health Response Act 2020

    b. epidemic management notices and immediate modification orders made under the Epidemic Preparedness Act 2006

    c. other provisions in primary and secondary legislation, such as those enabled through the COVID-19 Response (Further Management Measures) Legislation Act 2020; COVID-19 Response (Management Measures) Legislation Act 2021; COVID-19 Response (Urgent Management Measures) Legislation Act 2020; and Epidemic Preparedness (Epidemic Management— COVID-19—Parole Act 2002 and Sentencing Act 2002) Notice 2020.

13. It also enables powers for medical officers of health for the purposes of preventing the outbreak or spread of any infectious disease, under section 70 of the Health Act 1956. These powers were used throughout the earlier stages of the current pandemic.

14. **Annex 1: COVID-19 Orders and Notices** contains a list of all legal instruments that rely on the current Epidemic Notice being in place.

[1] Identified in the Health Act 1956

New Zealand's COVID-19 Context

15. The Government's response to COVID-19 has consistently been guided and defined by the combination of advice from the Director-General and legal advice from the Crown Law Office. As such, our response has evolved throughout the pandemic, evidenced by our shift from the elimination strategy, to the minimisation and protection strategy, and now to a new long-term approach to managing COVID-19.

16. To ensure our response remains effective and proportionate, regular public health risk assessments (PHRA) are undertaken to determine the most appropriate set of public health measures required to manage the pandemic at the time of assessment.

17. The most recent PHRA, undertaken on 17 August 2022, noted that New Zealand's current COVID-19 outbreak is waning, with reducing case numbers, hospitalisations, and deaths. Modelling suggested that this trend should continue for some time, based on current settings.

18. Given this, the PHRA recommended a step-down from most mandatory measures to more voluntary measures, to ensure that our response remains proportionate to the current risk posed by COVID-19, while also continuing to reduce hospitalisations and deaths from COVID-19. In light of this, the PHRA advised that an appropriate review time would be 4-6 weeks from the date of any decision on measures.

19. The next PHRA is planned for around 6 October 2022, which will provide the basis for further advice to Ministers in mid-October on whether public health measures relying on orders under the COVID-19 Public Health Response Act 2020 continue to be proportionate and justified beyond this time.

20. I have recommended to Cabinet, for consideration on 12 September 2022, to remove most mandatory requirements, and retain:

    a. mandatory 7-day case self-isolation (from date of symptom onset or date of test if asymptomatic)

    b. requirements for air travellers into New Zealand to provide information for contact tracing purposes prior to departure

    c. masks requirements for visitors in healthcare settings including primary care, urgent care, hospitals, aged residential care and disability-related residential care

21. Point-of-care testing regulation will also remain in place to support the isolation requirements above.

22. These remaining mandatory measures are designed to reduce transmission of COVID-19 and to lower cases, hospitalisations, and deaths, as well as maintain preparedness in the face of new variants. The absence of these specific measures, with cases at their present level, risks a resurgence of cases. This is likely to not only increase hospitalisations and deaths but also to result in significant disruption to essential governmental and business activity.

Legal test for renewal

23. The Epidemic Notice may be renewed if the Prime Minister, with the agreement of the Minister of Health, and on the written recommendation of the Director-General, is satisfied that the effects of the outbreak of COVID-19 are likely to continue to disrupt

essential governmental and business activity in New Zealand (or parts of New Zealand) significantly.

S9(2)(h)

[redacted]

Precautionary approach

31. While the prevalence of COVID-19 in the community has fallen from peaks earlier this year, there remains a level of unpredictability about the progress of the pandemic. The number of cases and hospitalisations due to COVID-19 is expected to continue to change in ways that cannot always be accurately predicted through modelling, particularly if changes are made to the public health measures, which have to date, contributed to the reduction in the number of cases and hospitalisations.

32. Experience overseas, such as in the United Kingdom, has also been that reducing restrictions too quickly has the potential to drive surprisingly high levels of transmission of the virus, and consequently increased hospitalisations and disruption to essential services. The PHRA noted that it is desirable to retain measures to maintain the downward trajectory and 'step down' our response, rather than immediately revoking all measures, as one way to manage this risk.

33. Furthermore, I am conscious of the significant consequences, if such an increase in transmission were to occur. In particular:

    a. the PHRA noted that vulnerable communities are likely to be disproportionately impacted by increasing levels of COVID-19. The hospitalisations and impacts outlined above may be significant for some communities and not felt at all for others. We know for example that the hospitalisation rate for Māori is approximately 2.3 times higher than that for the European or Other group, and Pacific Peoples it is 3.1 times higher.

    b. feedback received from Whaikaha – the Ministry for Disabled People indicates that disability-focussed COVID-19 data is poor and that disabled people and tāngata whaikaha Māori may be at disproportionate risk because of the voluntary compliance required by the New Zealand population. There was a strong preference for the continuation of mandated public measures.

    c. our understanding of the long-term symptoms of COVID-19 for certain people (long COVID) is still developing. Unlike other infectious diseases which have been circulating in our community for many years, such as influenza, there remains significant uncertainty about what the impact of COVID-19 may be years from now.

34. It is not practicable to wait until we have certainty on these matters before making a decision on the renewal of the Epidemic Notice, because doing so may preclude an effective and proportionate response to the risk we currently face or are likely to face in the near future.

35. For these reasons, I am taking a precautionary approach to my analysis, and where there is doubt, erring on the side of caution. However, a recommendation to renew the Epidemic Notice must be based on evidence that significant disruption to essential governmental or business activity is likely to continue, not simply to 'stay ready' for future variants.

Analysis

36. The recent decline in case numbers and hospitalisations is encouraging and has been in a context where there is a suite of mandated measures.

37. In assessing whether the test above has been satisfied, I am considering whether, in the absence of the public health measures recommended to Cabinet, it is likely that there could be significant disruption to essential governmental and business activity.

Epidemic Notice test

Summary of modelling

38. Since the PHRA on 17 August 2022, further modelling has been undertaken by COVID Modelling Aotearoa to explore a range of scenarios to reflect the uncertainty around the potential spread of COVID-19 in the absence of the recommended public health requirements. The modelling is summarised in more detail in **Annex 2**, and shows:

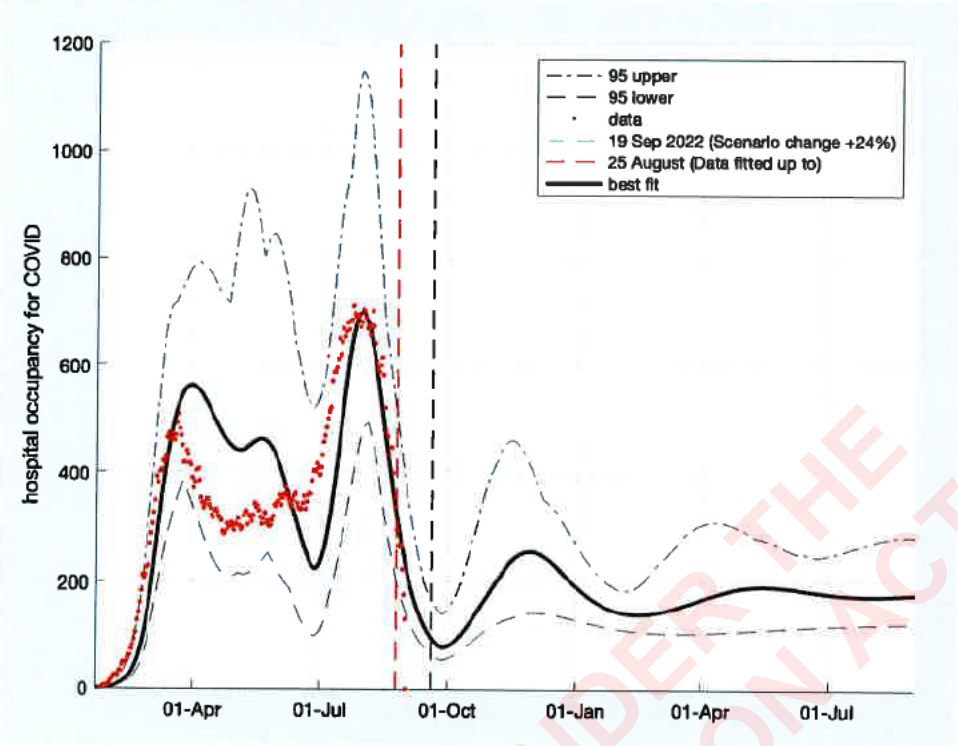
    a. Within the first month, the absence of recommended public health requirements compared with health settings to be implemented on 12 September is modelled to increase total cumulative hospital admissions from 368 to between 535 and 729 and increase deaths from 78 to between 98 and 121.

    b. Across the scenarios, daily hospital bed occupancy for COVID-19 is likely to continue its current decline, but experience another peak (associated with the easing of restrictions and waning immunity) at between 200 and 250 beds occupied - this is significantly lower than the peak of 700 beds occupied in the July BA.5 wave. Previous modelling assuming retention of current measures[2] suggests that hospital bed occupation would decline to a negligible level through the remainder of 2022, before another wave in late 2022 to early 2023, but this modelling has a very high level of uncertainty about the size and timing of this wave.

    c. Given the variability inherent in the inputs to the model, there is a broad range of possible hospital occupancy levels and timings of peaks.

[2] Seven-day case and household contact isolation, masks at Orange settings

Figure 1: Hospital occupancy for COVID-19 under the more pessimistic scenario



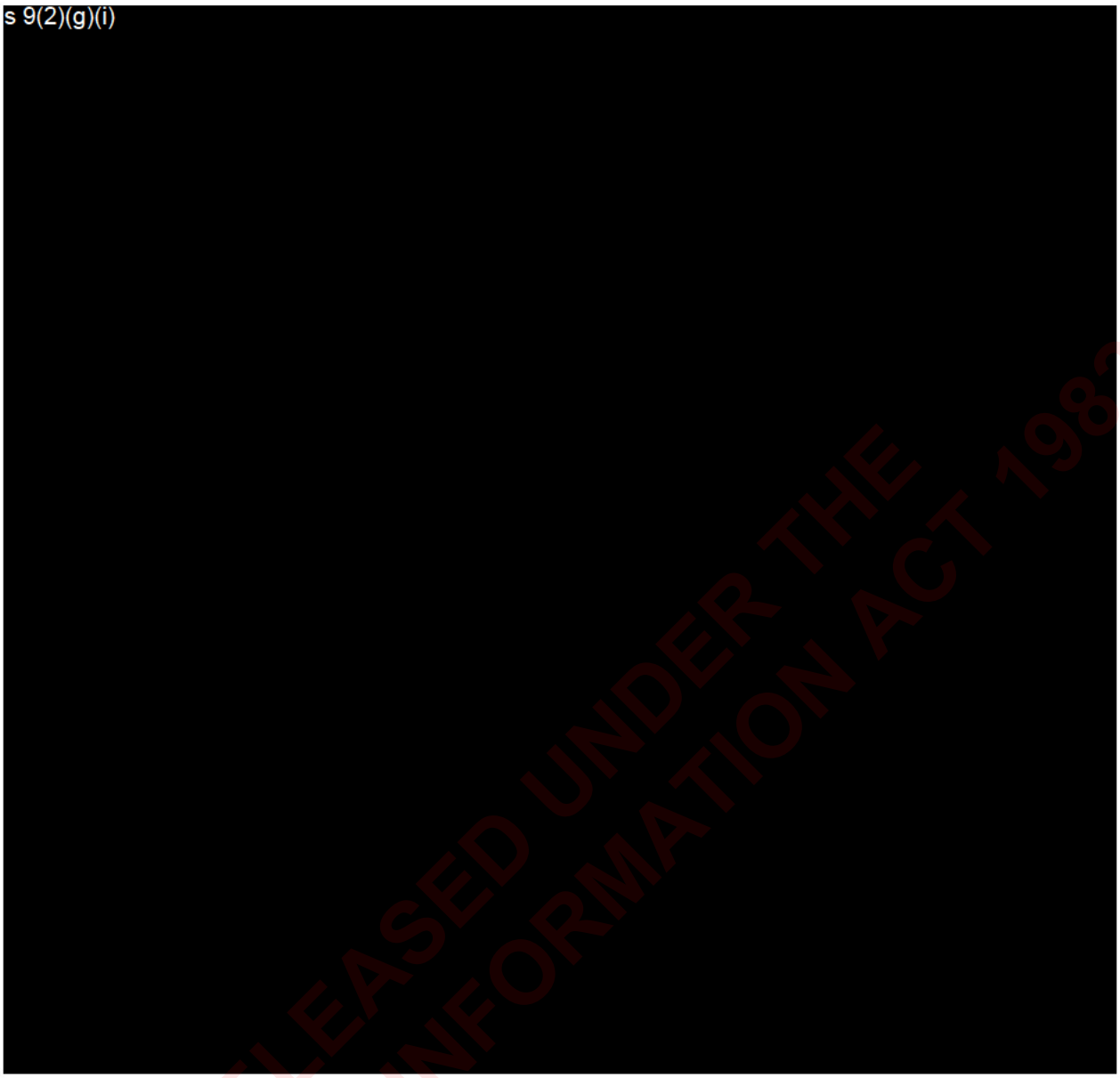
39. **Annex 2: Summary of indicative modelling on impact of removing all mandated public health measures** provides a fuller summary of this modelling reflecting uncertainty in two dimensions:

    a. A reduction in the share of people who are infected taking any action to reduce transmission. This could be due to people ignoring their positive result or choosing not to test in the first case.

    b. A reduction in the average effectiveness of actions taken to reduce transmission. This could be due to people isolating for a shorter period of time, or only avoiding high risk settings.

40. The optimistic scenario reflects most/all (at least 75% of) people continuing to take action to reduce transmission and this action still being relatively effective (at least 75% as effective as the current requirement).

41. The pessimistic scenario reflects fewer people (perhaps 25% to 50%) continuing to take action to reduce transmission, and this action being less effective on average (around 50% as effective as the current requirement).



Disruption to essential governmental activity – Health sector

43. I consider that in the absence of the public health measures recommended to Cabinet, it is likely that there will continue to be significant disruption to critical health services.

44. Te Whatu Ora reports that unplanned leave across many employee groups due to COVID-19, and other winter illnesses, continues to be a significant problem affecting staffing. The degree to which sectors are already affected by staff shortages and absenteeism is a critical feature in determining the impact of COVID-19 across New Zealand. This is particularly acute in the health sector.

45. Removing measures will have an impact on the health sector in the short term. Removal of all mandatory measures is expected to increase total hospital admissions by 280 to 535 over the next six weeks. As shown in Figure 1, daily hospital occupancy is likely to peak at between 200-250, but could reach up to 450 over this time (significantly below than the 700 July peak). Te Whatu Ora reports that many hospitals remain at Red with high occupancy levels and high numbers of respiratory virus case numbers (including COVID-19).

s 9(2)(g)(i)

[redacted]

47. It should be noted that COVID-19 currently represents 3-4% of total hospital occupancy (approximately 270 people in hospital with COVID-19). For context, the peak number of people hospitalised with COVID-19 at any one time was 1016, in March 2022 (equivalent to around 13% of total hospital occupancy). The more recent peak was around 700 in July 2022 (around 9% of total hospital occupancy). However, these numbers are not in themself determinative of the marginal impact of COVID-19 hospitalisations on hospitals, or the scale of hospital resources required to manage COVID-19 cases, which due to extra requirements such as PPE and isolation from other patients, require a high level of hospital resource per admission.

48. There are two related aspects to this:

a. we need to ensure we are calibrating our overall health resource appropriately, in properly responding to other non-COVID-19 illness or issues, such as measles, monkeypox, or seasonal illness

b. we still want to keep infections and illness that specifically demand a high level of health sector resource down, such as COVID-19, to ensure it does not create a disproportionate burden on the health system.

49. Planned care continues to be disrupted and will likely experience further, potentially significant disruption if measures are removed. An increase in hospitalisations prevents planned care from taking place. The impact of deferring this care increases with time, as conditions become more acute demanding a greater amount of health sector resource.

Disruption to essential governmental activity – other sectors

50. The Ministry of Justice advises that a spike in COVID-19 cases would have a material effect on the operation of the courts. There are a number of indicators of court performance, but one of the key metrics is the completion of court 'events' (the various court appearances and hearings that are required to progress a case). From 1 February to 8 July 2022, completed court events averaged 94% of the pre-delta (August 2021) level nationally. This disruption has been less than occurred earlier in the pandemic, as courts are now able to be run safely in a COVID-19 environment and the nature of the virus has changed too. But, without doubt, a spike would result in delays that will continue to have a significant impact on the court participants involved – defendants, victims, witnesses and families.

51. The response to the pandemic, and Omicron, has required active and continuous management of court resources. Additional judges and staff have been funded, on a temporary basis, to help deal with the effects of delays in the courts of the last few years.

52. There is also specific legislation that currently applies in respect of the courts. The COVID-19 Response (Courts Safety) Legislation Act 2022 allows specific health measures to be put in place in respect of courts if that is reasonably necessary in the interests of justice and to protect health and safety in the courts.

53. With regard to the education sector, preliminary analysis of indicates that since 2020, 41% of school-teachers have reported a positive COVID-19 result. The Ministry of Education advises that, while COVID-19 has had a significant additional impact, it is difficult to disentangle disruption to schools and services due to COVID-19 from winter illnesses and pre-existing pressures such as teacher supply constraints. Disruption is uneven with some schools and service more impacted than others:

    a. school attendance and in person learning are up and cases amongst school age children continue to decline

    b. the education workforce remains under pressure as schools struggle to find relievers as staff are staying home because they are ill, isolating, or caring for others-this has impacts on teachers, school leaders and learners

    c. early learning services face similar workforce pressures.

54. Other agencies have noted a degree of ongoing disruption – particularly due to absenteeism – but overall report that it is difficult to determine the extent to which COVID-19 is the cause. They also note that systems are now much more resilient and prepared to deal with case increases than earlier in the outbreak.

Disruption to essential business activity

S9(2)(h) [redacted]

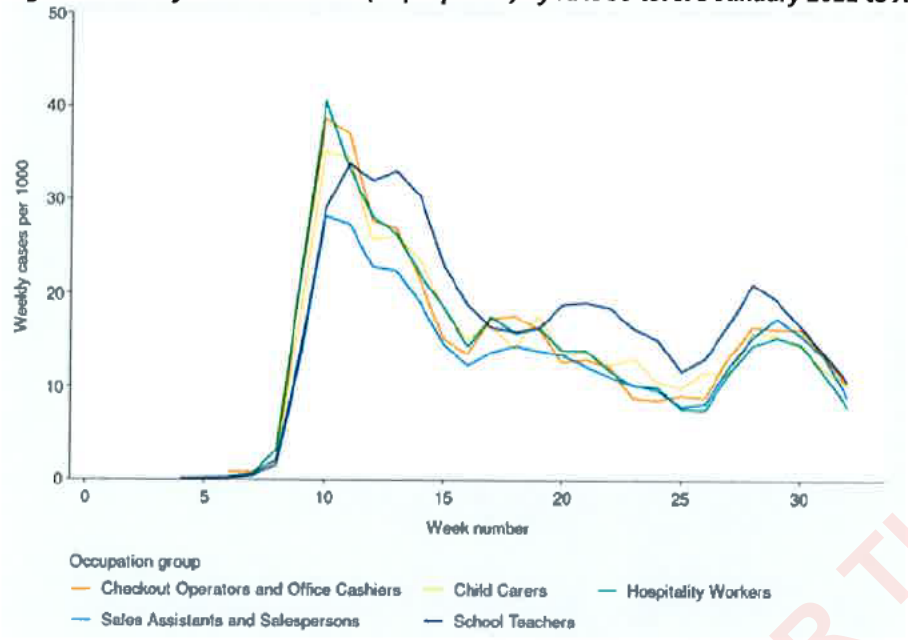
56. What constitutes essential business activity is context dependent and has been the subject of extensive processes led by the Ministry of Business, Innovation and Employment. For this advice, I consider essential business at the general level to include businesses such as supermarkets, pharmacies, childcare, and some logistics activity. In practice however, essential business activity has been considered to be far broader.

57. Preliminary analysis of non-governmental occupations, using the linking of COVID-19 testing to the IDI indicates that the most affected by being COVID-19 cases indicates that child carers[3] (38%), hospitality workers (37%) and checkout operators (36%) are among the top occupations most affected by COVID-19 infections

58. Timeseries analysis of the above data limited to 2022 (Figure 1), shows that cases most affected occupations are declining after July peak. However, they are still higher than in early February 2022. Current measures are supporting the declining trends.

[3] Child Carers provide care and supervision for children in residential homes and non-residential childcare centres

Figure 2: Weekly COVID-19 cases (self-reported) by ANSCO level 3 January 2022 to August 2022



59. Data from the Household Labour Force Survey shows the number of people citing COVID-19 related reasons as the main reason for being away from work decreased by 62.7 percent from the March 2022 to the June 2022 quarter.

Figure 3: Household Labour Force Survey – total hours away from work (000s) – June 2019 to June 2022

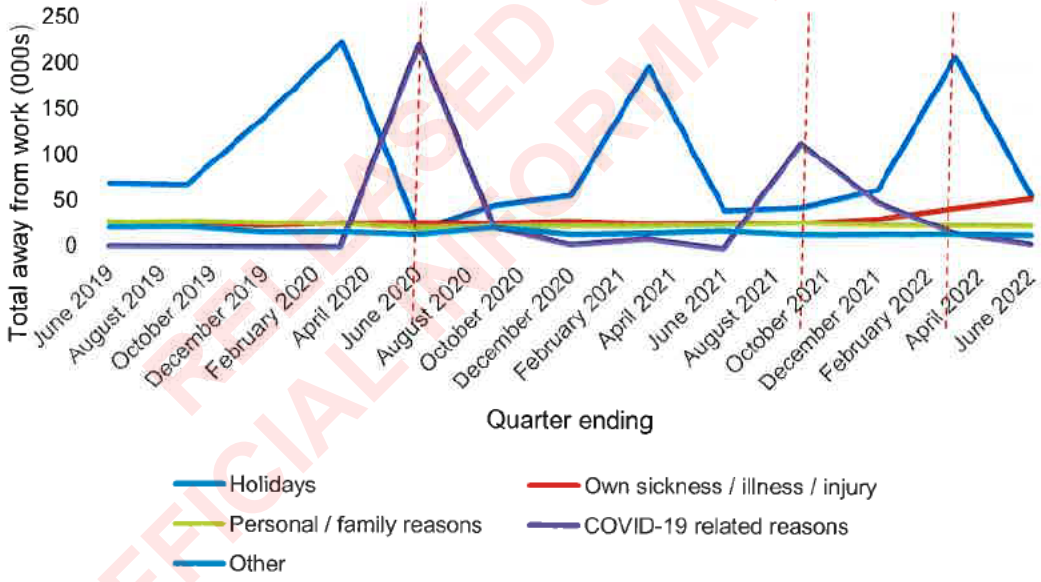
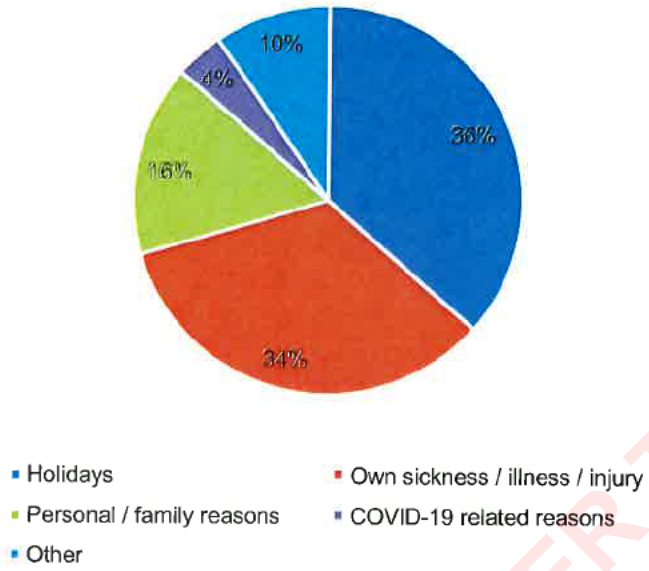


Figure 4: Main reason for being work, June 2022 quarter (Household Labour Force Survey)



60. The New Zealand economy has overall been resilient to the transmission of the Delta and the Omicron variants across the country, although some businesses and households have been impacted more than others.

61. Treasury has advised that there is no indication in high level activity indicators like card spend and people movements of ongoing impacts that can be attributed to COVID-19. Movement to essential businesses such as supermarkets and pharmacies is above pre-pandemic levels.

62. The COVID-19 Leave Support Scheme data provides a useful proxy for disruption. Treasury advises that the general trend across industries is that the proportion of jobs supported by the scheme was much lower during the BA.5 outbreak in July than it was during the initial Omicron outbreak. For example, in Transport, Post and Warehousing the proportion of jobs supported over July was 4% (compared to 14% in March), or around 1% per week. Treasury expects support levels to drop off further into the future.

63. The Ministry of Transport advises that freight and public transport services (airlines, ferries and buses) are currently experiencing significant staffing pressures due to labour shortages in the sector. Any significant increase in COVID-19 cases is likely to have some disruption on public transport and freight services as there is very little reserve in terms of the employment pool available to cover absences from those who become ill. [Commercial – in Confidence] There was an application from an airline to the Director-General in July 2022, for an exemption to the requirement for cases to isolate as a result of significant disruption to a critical service. While the exemption was not granted, it was established that staff absences due to COVID-19 were causing disruptions to airline and Cook Strait ferry services during the winter peak.

64. I do note that variants can impact different demographic groups and may not be reflected in some of this data. For example, where a variant affects the very young or

very old, it may not necessarily have as significant an economic impact as variants that affect demographics that form a large part of the workforce requiring support.

Equity considerations

65. An important caveat is the equity impacts of these changes have not been modelled, in part due to limited available data. However, based on discussion with the modelling team and understanding of other public health issues, moving some settings from mandates to guidance is likely to have inequitable outcomes.

    a. Māori and Pacific peoples are more at risk of severe negative health outcomes than non-Māori non-Pacific of the same age.

    b. Shifting to guidance is likely to disproportionately affect those who do not have the ability to choose to follow the guidance. This may include: people in precarious employment, those unable to work from home, workers with limited sick leave and populations with other socioeconomic disadvantage.

66. While not part of the recommendations proposed to Cabinet, additional supports for people to isolate effectively (such as additional sick leave and leave support) could help mitigate these inequitable outcomes.

Recommendation

67. In my view, in the absence of the public health measures recommended to Cabinet, significant disruption to critical health services and other essential services, including transport, is likely.

68. In addition to this, I have also considered the marginal pressure that increased infections, cases, hospitalisations, and deaths from COVID-19 is likely to place on essential governmental and business activity. In an environment with high levels of absenteeism and in a tight labour market and skills shortages, as well as continued staffing pressures within the hospital system, further disruption from increased cases and hospitalisations would likely have a significant impact as we have seen before.

69. That said, given the downward trajectory of infections, cases, hospitalisations, and deaths, I consider that a much shorter renewal period is appropriate. Maintaining the current measures in the short term is appropriate to be precautionary and factor in uncertainty about the impact of lifting measures. In the medium term, the level of cumulative infections, cases and hospitalisations appears at this stage to be much reduced and more able to be absorbed by the health system – even with current staff shortages and pressures.

70. This conclusion is supported by the PHRA on 17 August 2022 which advised that, to continue managing infections, cases, hospitalisations, and deaths from COVID-19 it is necessary to maintain some mandated measures. These mandated public health measures have been recommended for Cabinet's consideration on 12 September 2022, based on this advice.

71. Based on this assessment and the most recent public health advice, I recommend a precautionary approach of renewing the Epidemic Notice for a period of 5 weeks, until 20 October 2022.

Legal consequences of the Epidemic Notice not being renewed

72. For context, I provide information on the implications if the Epidemic Notice is not renewed:

    a. no new COVID-19 orders can be made or amended. 9(2)(h) [redacted]

    b. all other instruments and powers dependent on the Epidemic Notice lapse immediately or within a specific timeframe

73. The COVID-19 Public Health Response Act 2020 provides additional basis for making orders.

    a. The use of COVID-19 general or specific orders can be authorised by the Prime Minister directly under s8(c) of the Act, if there is **a risk of an outbreak or the spread of COVID-19.** This is a different test than for issuing or renewing an Epidemic Notice.

    b. If a state of emergency or transition period regarding COVID-19 is in force under the Civil Defence Emergency Management Act 2002.

S9(2)(h) [redacted]

75. Given my recommendation above, I do not consider it necessary to make a Prime Minister authorisation for the use of COVID-19 orders at this time.

Next steps

76. Should you agree to renew the Epidemic Notice, orders will be amended and prepared to give effect to Cabinet's anticipated decisions on 12 September 2022. On Thursday 8 September 2022, the Minister for COVID-19 Response received advice regarding these changes [HR20221395 refers].

77. The renewal of the Epidemic Notice will take effect upon publication in the Gazette and will expire on 20 October 2022, unless earlier renewed or revoked.

78. Once the renewal of the Epidemic Notice is signed, a copy of that renewal must be presented as soon as possible to Parliament.

79. The next PHRA, which will inform a subsequent renewal decision will take place on or around 6 October 2022.

80. If you do not agree to renew the Epidemic Notice, further advice will be provided concerning the use of a s8(c) authorisation for limited use of orders under the COVID-19 Public Health Response Act 2020.

81. If an Epidemic Notice expires, a new notice could be made relatively swiftly if the grounds are met, within 48-72 hours. There are also alternative mechanisms available if mandatory public health measures are necessary to respond urgently in the interim, such

as the use of powers under s70 of the Health Act 1956 by medical officers of health on the authority of the Minister of Health.

Consultation

82. The following agencies have been consulted to collect information to inform advice about the grounds for renewal of the Epidemic Notice. This includes Crown Law Office, the Department of Corrections, Department of the Prime Minister and Cabinet, the Ministry of Business, Innovation and Employment, the Ministry of Education the Ministry of Justice, the Ministry for Primary Industries, Ministry of Social Development, the Ministry of Transport, the New Zealand Customs Service, the New Zealand Police, Te Aka Whai Ora, Te Whatu Ora, the Treasury, and Whaikaha. Additionally, consultation has been undertaken with the COVID-19 Chief Executives Board.

83. Engagement more broadly on changes to public health restrictions has occurred as part of the preparation of advice for Cabinet.

ENDS.

Annex 1: COVID-19 Orders, Notices and Provisions in force that rely on the Epidemic Notice

COVID-19 Orders[4]	**Status**
COVID-19 Public Health Response (Air Border) Order 2021	Amendment recommended to remove all requirements except for the requirement to provide information for contact tracing purposes.
COVID-19 Public Health Response (Isolation and Quarantine) Order 2020	Revocation recommended
COVID-19 Public Health Response (Maritime Border) Order (No 2) 2020	Revocation recommended
COVID-19 Public Health Response (Point-of-Care Tests) Order 2021	Amendment recommended
COVID-19 Public Health Response (Protection Framework) Order 2021	Revocation recommended
COVID-19 Public Health Response (Self-isolation Requirements and Permitted Work) Order 2022)	Amendment recommended to remove all requirements except for the requirement for cases to self-isolate for 7 days.
COVID-19 Public Health Response (Testing for COVID-19) Order 2022	Revocation recommended
COVID-19 Public Health Response (Vaccinations) Order 2021	Revocation recommended
Epidemic Management Notices	**Status when Epidemic Notice expires**
Epidemic Preparedness (Epidemic Management – COVID-19) Notice 2020	These notices expires when the Epidemic Notice expires or is revoked.
Epidemic Preparedness (Epidemic Management – COVID-19) Notice (No 2) 2020	
Epidemic Preparedness (Epidemic Management – COVID-19 – Parole Act 2002 and Sentencing Act 2002) Notice 2020	

[4] There are also associated Director-General Health notices and exemptions that will cease to have effect when the orders under which they are made are revoked.

Epidemic Preparedness (Epidemic Management – COVID-19 – Parole Act 2002) Notice 2022	

Immediate Modification Order	Administering agency	Status when Epidemic Notice expires
Epidemic Preparedness (Customs and Excise Act 2018—Appeals) Immediate Modification Order 2020	New Zealand Customs Service	An Authority may accept an application for an extension of time if it is made no later than 20 working days after the EPN expires or is revoked
Epidemic Preparedness (Local Government Act 2002) Immediate Modification Order 2020	Department of Internal Affairs	Automatically revokes when EPN expires
Epidemic Preparedness (Oaths and Declarations Act 1957) Immediate Modification Order 2020	Ministry of Justice	Automatically revokes when EPN expires
Epidemic Preparedness (Protection of Personal and Property Rights Act 1988—Enduring Powers of Attorney) Immediate Modification Order 2020	Ministry of Justice	Automatically revokes when EPN expires
Epidemic Preparedness (Sale and Supply of Alcohol Act 2012—Licence Application Inquiries) Immediate Modification Order 2020)	Ministry of Justice	Automatically revoked 30 working days after the EPN expires
Epidemic Preparedness (Social Security Act 2018—Temporary Additional Support) Immediate Modification Order 2020	Ministry of Social Development	In place although no longer live
Epidemic Preparedness (Wills Act 2007—Signing and Witnessing of Wills) Immediate Modification Order 2020	Ministry of Justice	Automatically revokes when EPN expires

Annex 2: Summary of indicative modelling on impact of removing all mandated public health measures

- Modelling has considered the impact of removing all mandated public health measures.
- This modelling extends the modelling presented in the recent Cabinet paper on the future of the COVID-19 Protection Framework. It provides multiple scenarios reflecting the uncertain impact of these policy changes.
- These modelling results have been produced rapidly to help inform policy advice. They should be considered as indicative as there are significant uncertainty around the impact of policy changes and the level of immunity in the population.
- Note that these figures may not align with reported in the Ministry of Health press releases, as those figures include with-covid hospitalisations (whereas this modelling focuses on hospitalisations for-covid).

Key points:

- There is significant uncertainty around both the effect of removing the mandated public health measures and the level of immunity in the population over the coming months.
- Modelling has considered a range of scenarios to reflect this uncertainty.
- Within the first month, the absence of recommended public health requirements compared with current health settings is modelled to increase total cumulative hospital admissions from 368 to between 535 and 729 and increase deaths from 78 to between 98 and 121.
- Across the scenarios, **daily hospital bed occupancy for COVID-19 is likely to continue its current decline, but experience another peak (associated with the easing of restrictions and waning immunity) at between 200 and 250 beds occupied** - this is significantly lower than the peak of 700 beds occupied in the July BA.5 wave. Previous modelling assuming retention of current measures suggests that hospital bed occupation would decline to a negligible level through the remainder of 2022, before another wave in late 2022 to early 2023, but this modelling has a very high level of uncertainty about the size and timing of this wave.
- In general, the short-term peak in cases and hospitalisations can be mitigated by phasing policy changes over a longer period of time.

Equity

- An important caveat is the equity impacts of these changes have not been modelled, in part due to limited available data. However, based on discussion with the modelling team and understanding of other public health issues, moving some settings from mandates to guidance is likely to have inequitable outcomes.
    - Māori and Pacific peoples are more at risk of severe negative health outcomes than non-Māori non-Pacific of the same age.
    - Shifting to guidance is likely to disproportionately affect those who do not have the ability to choose to follow the guidance. This may include: people in precarious employment, those unable to work from home, workers with limited sick leave and populations with other socioeconomic disadvantage.
- Additional supports for people to isolate effectively (such as additional sick leave and leave support) could help mitigate these inequitable outcomes.

How do reductions in the share of cases choosing to isolate affect the reproductive number?

Modelling has considered how two factors affect the reproductive number (i.e. speed of transmission):

- A reduction in the share of infections taking any action to reduce transmission. This could be due to people ignoring their positive result or choosing not to test in the first case.

- A reduction in the average effectiveness of action to reduce transmission. This could be due to people isolating for a shorter period of time, or only avoiding high risk settings.

The table below shows the increase in the reproductive number for a range of different assumptions. Assuming no reduction in case isolation gives an increase of 11.4%, which is the increase associated with removing mask mandates and contact quarantine with testing only when symptomatic. Percentage increases beyond that vary significantly from 15% to 26%. In general, having a large share of cases taking some action is more effective than some cases taking significant action.

		Reduction effectiveness of actions			
		0%	**25%**	**50%**	**75%**
Reduction in proportion of people taking action	**0%**	11.4%	15.2%	18.1%	20.5%
	25%	16.0%	18.5%	20.4%	22.1%
	50%	20.0%	21.7%	22.9%	24.0%
	75%	24.0%	24.5%	25.2%	25.6%

How does an increase in the reproductive number affect cases, hospitalisations and deaths?

Because of the significant uncertainty in how people respond to a removal mandated case isolation, modelling has considered three scenarios:

- A baseline change, with an 8.5% increase in the reproductive number5.
- An optimistic scenario, with a 17% increase in the reproductive number.
- A middle scenario, with a 20.5% increase in the reproductive number.
- A pessimistic scenario, with a 24% increase in the reproductive number.

These scenarios are compared against a scenario assuming settings remain as they were in August 2022 (0% increase) and a scenario modelling the public health measures recommended to Cabinet with removed mask mandates, removed contact quarantine with daily testing, but maintaining case isolation (8.5% increase).

Factors that would shifting us closer to the optimistic scenario could include:

- Achieving high levels of testing in the community.
- Maintaining strong norms that people should work from home if unwell.
- High voluntary adherence to mask and case isolation guidance.

Policy changes that increase transmission will tend to have two effects:

- In the short-term, a large increase in cases, hospitalisations and deaths. The absolute size of this change will be driven by the level of immunity in the population. This impact wanes over time as infection-induced immunity increases.
- In the long-term, a slightly higher steady state level of cases, hospitalisations and deaths. This impact is smaller in percentage terms but is persistent over time.

In general, the short-term peak in cases and hospitalisations can be mitigated by phasing policy changes over a longer period of time. This smooths out the peak and also allows decision makers to adjust their approach if the path of the outbreak differs from modelled projections.

The table below shows the increase in cases, hospitalisations and deaths under these scenarios. In the short-term, there is a large relative increase in cases, hospitalisations and deaths. However, the absolute increases may be smaller than expected with hospitalisations increasing by roughly 250 to 500 over a month and deaths increasing by 30 to 60. Relative increases are smaller over the long-term, but larger

[5] This scenario is based on the health measure changes to be announced and implemented on 12 September.

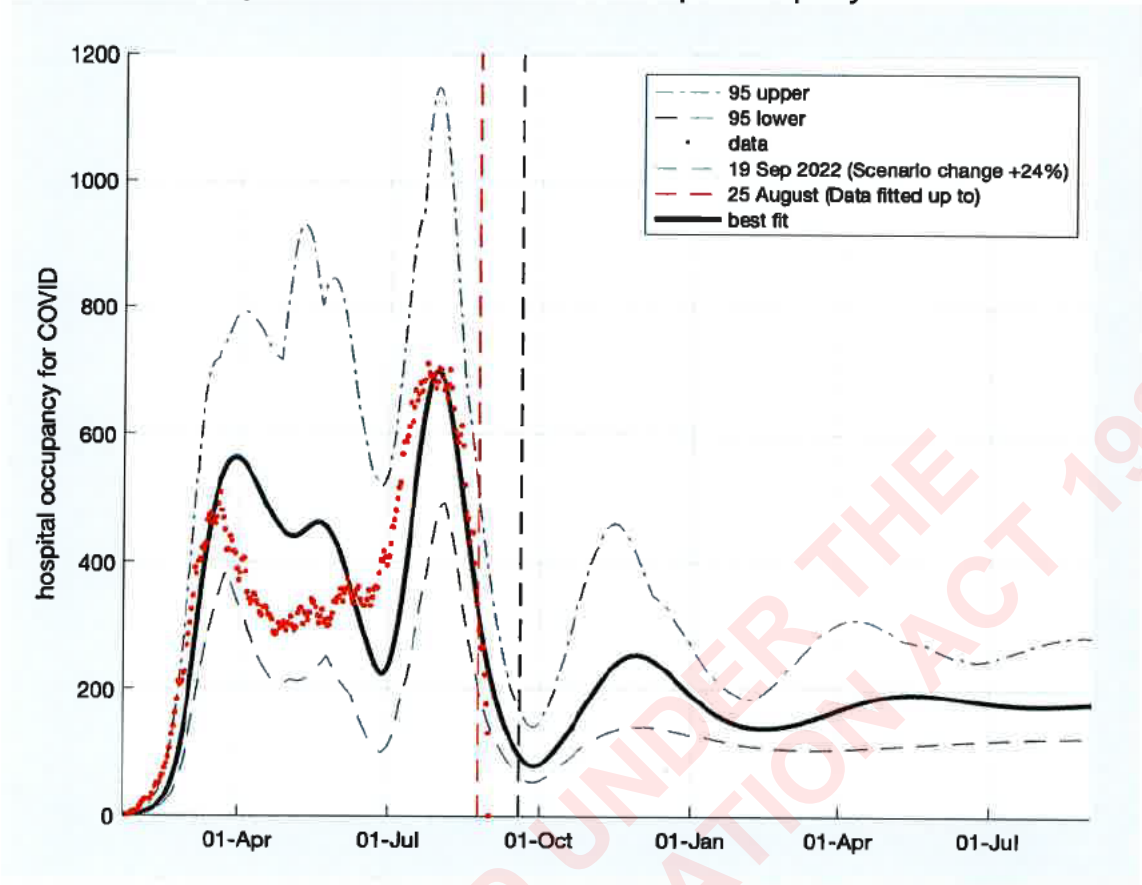
in absolute terms, with hospitalisations increasing by roughly 1,500 to 2,000 and deaths increasing by roughly 400 to 600.

s 9(2)(g)(i)

The figure below shows for-covid hospital occupancy for the pessimistic scenario (other scenarios shown further below). Note these figures may not align reported in the Ministry of Health press release, as those figures include with-covid hospitalisations.

The model projects hospital occupancy falling to around 100 occupied beds in late September. The policy change results in an increase in hospitalisations over the following months. The best fit of the model peaks at roughly 250 beds, however the uncertainty around this peak ranges from around 450 occupied beds on the high end, to under 200 beds on the low end. Despite the large increase in transmission, the modelling suggests that accumulated immunity would keep peak hospitalisations below the BA.5 wave peak.

Figure 1: Impact of pessimistic scenario on for-covid hospital occupancy



The shape of the hospital occupancy curve is broadly similar for the optimistic and middle scenarios (shown further below), but with peak hospital occupancy being around 50 beds (optimistic) and 30 beds lower (middle) than the pessimistic scenario.

Assumptions

This modelling uses a large number of assumptions that are important to keep in mind:

- **Mask mandate assumptions.** Mask mandates are assumed to reduce mask usage that in turn causes a roughly 20% reduction in transmission outside the home.
- **Contact quarantine assumptions.** This modelling uses very similar assumptions to those used in the August monthly review of case isolation and contact quarantine.
- **Case isolation assumptions**. With mandated 7-day isolation, it is assumed that 90% of transmission for identified cases is prevented.
- **Long-term trajectory assumptions**. The model assumes that BA.5 is the prevalence variant for the next 12 months and no changes to vaccination eligibility (e.g. third boosters, second boosters for more groups) and no change in available therapeutics.
- **Peaks and troughs assumptions.** Because this is a single national model, it may not capture the different size, shape and timing of peaks at a district or regional level. Therefore, the model may overestimate peaks and underestimate troughs, if outbreaks in different population groups are not aligned.
- **Uncertainty around modelled estimates.** The provides confidence intervals around estimates of cases, hospitalisations and deaths. This range reflects unknowns such as the share of infections detected and the speed of waning immunity. The model is fit to data up to XX August, which reduces some of this uncertainty.

Figure 2: Impact of optimistic scenario on for-covid hospital occupancy

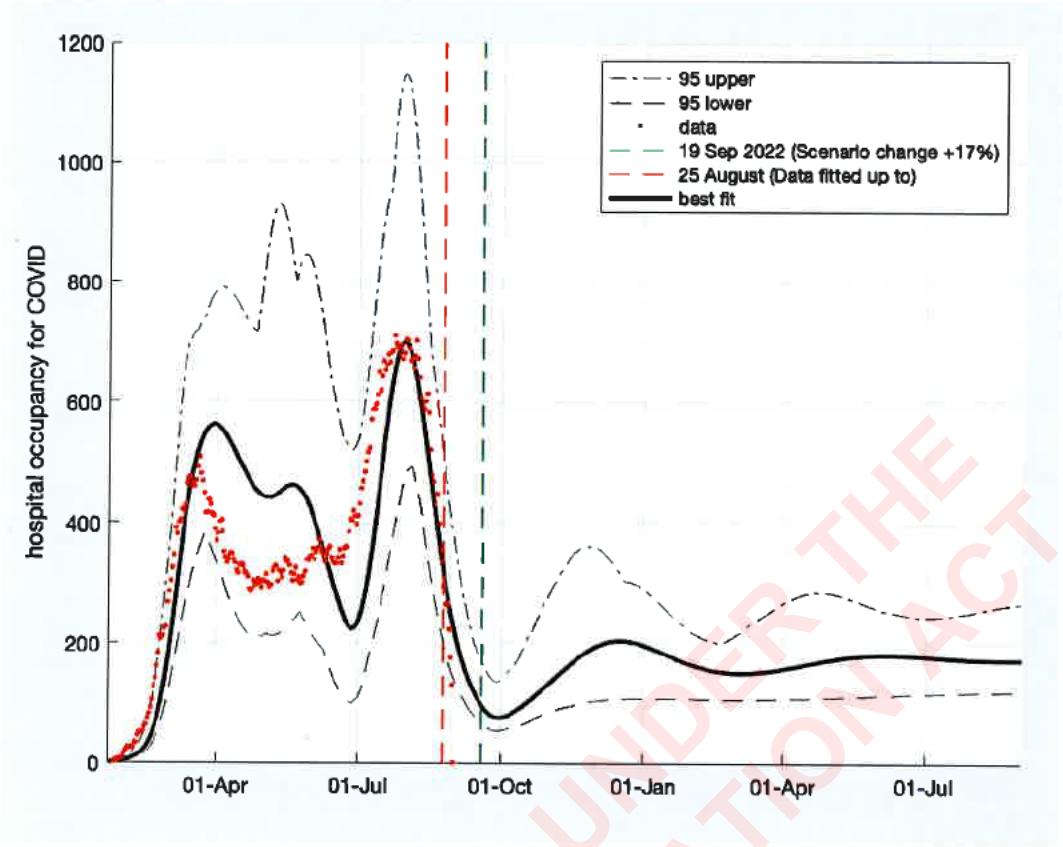


Figure 3: Impact of middle scenario on for-covid hospital occupancy