Document 9

MANATŪ HAUORA
MINISTRY OF HEALTH

Briefing

Authorising the use of COVID-19 Orders under section 8(c) of the COVID-19 Public Health Response Act 2020

Date due to MO:	16 February 2023	**Action required by:**	16 February 2023
Security level:	IN CONFIDENCE	**Health Report number:**	H2023020307
To:	Rt Hon Chris Hipkins, Prime Minister		
Copy to:	Hon Dr Ayesha Verrall, Minister of Health Hon Kiri Allan, Minister of Justice		
Consulted:	Health New Zealand: ☒ Māori Health Authority: ☒		

Contact for telephone discussion

Name	Position	Telephone
Dr Diana Sarfati	Director-General of Health	s 9(2)(a) [redacted]
Stephen Glover	General Manager COVID-19 Policy, Strategy, Policy and Legislation	

Minister's office to complete:

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☐ See Minister's Notes	☐ Withdrawn	

Comment:

Authorising the use of COVID-19 Orders under section 8(c) of the COVID-19 Public Health Response Act 2020

Security level:	IN CONFIDENCE	**Date:**	16 February 2023
To:	Rt Hon Chris Hipkins, Prime Minister		

Purpose

1. This briefing recommends you authorise the use of specific COVID-19 orders under section 8(c) of the COVID-19 Public Health Response Act 2020 (the Act).

Summary

2. This briefing should be read in parallel with the Cabinet paper 'COVID-19 public health measures' to be considered on 20 February 2023 following the Public Health Risk Assessment (PHRA) on 26 January 2023. The PHRA is attached at Annex 1. The expectation is that the measures agreed should remain in place until further advice is provided following the next PHRA in March 2023, unless circumstances change materially in the interim.

3. The following COVID-19 orders are intended to continue until 28 April 2023:

   a. the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022

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

   c. the COVID-19 Public Health Response (Masks) Order 2022.

4. These COVID-19 Orders would provide for the following measures recommended to Cabinet:

   a. retention of 7-day isolation periods for positive cases (including limited permitted movement for cases self-isolating)

   b. retention of point of care tests regulation (to support self-isolation requirements)

   c. mandatory masks in health service premises.

5. COVID-19 continues to pose a public health risk, which is different from other respiratory and communicable diseases. Without mandatory measures, it is likely that cases, hospitalisations, and mortality will be higher in the short-term and over this year, and this will increase pressure on health sector capacity. The size, timing, and duration of the next peak and baseline trends of cases, hospitalisations and mortality is uncertain due to the current variant mix in the community.

6. A change in case isolation requirements that results in transmission increasing by 10% (a plausible mid-point scenario) will cause an approximate 70% increase in peak bed occupancy in hospitals over the two months following the change (requiring around 150 - 175 extra beds to be occupied compared to status quo settings), with a disproportionate effect on vulnerable populations.

7. The number of people still completely susceptible to infection is approximately 800,000 of which 350,256 people are 70 years and older. Infections in this older age group are the main driver for hospitalizations.

8. In 2022 there were 2,319 deaths attributable to COVID-19 in New Zealand. This is approximately six times more than the number of people killed on the roads in 2022 (378), and just under two times the number of annual deaths due to colorectal cancer (approximately 1,200).

9. Based on comparison of age-adjusted rates, worst affected are Pacific people, who are 2.3 times more likely than the 'European and other' classification to be hospitalised with COVID-19, with Māori the next worst affected at 1.8 times more likely to be hospitalised with COVID-19.

10. Although case numbers are decreasing, transmission is likely to increase as people return to their indoor places of education or work in February 2023. It is considered appropriate to maintain the COVID-19 response measures in order to prevent the number of cases, hospitalisations, and mortality rates increasing significantly. Although infection trends are low currently this does not mean peak immunity has been reached. Infection trends will wax and wane as there will be new variants that escape prior immunity gained from infection.

11. The Prime Minister at the time previously authorised the making of COVID-19 orders under section 8(c) of the Act on 16 December 2022, after being satisfied there was a risk of an outbreak or the spread of COVID-19, by approving the COVID-19 Public Health Response (Authorisation of COVID-19 Orders) Notice 2022 (the Notice) which enabled the use of COVID-19 orders in relation to the following matters:

    a. self-isolation requirements for COVID-19 cases
    b. regulation of point-of-care tests
    c. mask requirements in health service premises.

12. The Notice will expire on 28 February 2023.

13. I recommend that you authorise the use of COVID-19 orders through to 28 April 2023 for self-isolation of positive cases, point-of-care tests regulation, and mask requirements in health service premises.

14. The new authorisation will have the same scope as the current authorisation. It will allow the Minister of Health to make and amend orders within the scope of the activities set out in the paragraph above. The scope of the orders could not be expanded to include, for example, isolation of contacts or masks on public transport, without your further authorisation.

Recommendations

15. I recommend you:

a) **Note** that Cabinet will consider changes to COVID-19 public health measures on Monday 20 February 2023. **Noted**

b) **Note** the making of COVID-19 Orders (generally or specifically) can be authorised under section 8(c) of the COVID-19 Public Health Response **Noted**

Act 2020 (the Act), if you are satisfied there is a risk of an outbreak or the spread of COVID-19.

c) **Note** that the COVID-19 Public Health Response (Authorisation of COVID-19 Orders) Notice 2022 (the current Authorisation) will expire on 28 February 2023. **Noted**

d) s 9(2)(h) [redacted] **Noted**

e) **Agree,** being satisfied that there is a risk of an outbreak or the spread of COVID-19, to authorise under section 8(c) of the Act the use of COVID-19 orders for:

i self-isolation requirements for COVID-19 cases **Yes / No**

ii regulation of point of care tests **Yes / No**

ii mask requirements in healthcare service premises. **Yes / No**

f) **Agree** to sign the Authorisation Notice, to be provided by Parliamentary Counsel Office, authorising the use of COVID-19 orders under section 8(c) of the Act for a duration of two months from 28 February 2023 to 28 April 2023. **Yes / No**

g) **Note** that the next Public Health Risk Assessment review of public health measures will take place in March 2023. **Noted**

h) **Agree** to proactively release this briefing, subject to any appropriate withholding of information that would be justified under the Official Information Act 1982. **Yes / No**

Dr Diana Sarfati
Director-General of Health | Te Tumu Whakarae mō te Hauora
Manatū Hauora | Ministry of Health
Date: 16/2/23

Hon Dr Ayesha Verrall
Minister of Health
Date: 19/2/23

Rt Hon Chris Hipkins
Prime Minister
Date:

Authorising the use of COVID-19 Orders under section 8(c) of the COVID-19 Public Health Response Act 2020

Background

Amendments to the Act

16. The COVID-19 Public Health Response Act 2020 (the Act) was due to expire in May 2023, however the COVID-19 Public Health Response (Extension of Act and Reduction of Powers) Amendment Act 2022 (the Amendment Act) extended the expiry date to 26 November 2024.

17. The Amendment Act came into effect on 26 November 2022 and scaled back the government's previous COVID-19 powers.

18. The measures needed at the start of the pandemic to contain the spread of COVID-19 such as lockdowns and Managed Isolation and Quarantine are no longer needed as there are now a range of other tools available to manage the virus within communities such as vaccination and antivirals.

19. The Act retains the ability to implement some limited public health measures to manage the ongoing impact of COVID-19 and potential new variants, for example through self-isolation and mask requirements, and other requirements as necessary on travellers to Aotearoa New Zealand.

20. Further details of the amendments to the Act are set out in Annex 2.

Authorisation under the Act

21. The Act provides alternative bases for making and amending orders besides the issuance of an epidemic notice:

    a. The use of COVID-19 orders (generally or specifically) can be authorised by the Prime Minister under section 8(c) of the Act, if the Prime Minister is satisfied there is a risk of an outbreak or the spread of COVID-19. This is a different test to that 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.

Current Notice

22. On 16 December 2022 the Prime Minister at the time made the COVID-19 Public Health Response (Authorisation of COVID-19 Orders) Notice (No2) 2022 (the Notice) which authorises the use of COVID-19 orders under the COVID-19 Public Health Response Act 2020 in relation to the following matters:

    a. self-isolation requirements for COVID-19 cases

    b. point-of-care tests regulation

    c. mask requirements in health services premises

23. The test for determining whether the use of COVID-19 orders can be authorised using section 8(c) of the Act is different to the test to be applied when determining whether the issuing of an epidemic notice is justified. However, the section 8(c) power is significant, and care is needed to ensure it is exercised prudently.

24. The Notice expires on 28 February 2023.

Cabinet consideration

25. On 20 February 2023 Cabinet will consider recommendations that it agree to retain the current mandatory public health measures based on a public health risk assessment held on 26 January 2023. These measures are:

    a. mandatory 7-day case isolation requirements (including allowing cases to return home by specified modes of transport and subject to infection prevention control measures being in place)

    b. mandated mask requirements for visitors to health care settings.

26. In addition, it is appropriate for the regulation of point of care tests to be maintained while mandatory self-isolation requirements are in place.

27. The decisions above carry the expectation that these measures should remain in place until 28 April 2023 unless circumstances change materially in the interim. The proposed 2 months duration of the recommended Authorisation Notice allows the measures to have a clear legislative basis over the intended period, pending the outcome of the next PHRA expected in March 2023 and decisions following that process.

s 9(2)(h)

[redacted]

s 9(2)(h)

s 9(2)(h)

[redacted]

Current state of COVID-19 risks

Status as at 26 January 2023

37. COVID-19 continues to pose a substantial public health risk, which is different from other respiratory and communicable diseases.

38. While overall case numbers, hospitalisations have declined from the late-December 2022 peak, Māori and Pacific Peoples continue to be overrepresented in case numbers, hospitalisations and mortality.

39. COVID-19 mortality has remained stable since increasing in mid-December 2022.

40. As people return to indoors locations through work, school and university, mixing rates will increase. The timing of the next COVID-19 wave is uncertain but may well coincide with the beginning of the winter respiratory illness season. The broad mix of variants in Aotearoa New Zealand adds to this uncertainty.

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

42. More information on the current state of the COVID-19 outbreak can be viewed in the PHRA (see Annex 1).

The difference mandatory measures make to transmission

43. A legal requirement to self-isolate remains a cornerstone of Aotearoa New Zealand's COVID-19 public health response. It significantly limits transmission of COVID-19 by breaking the chain of transmission by reducing the amount of infectious people having contact and infecting others within the community. In turn, this limits hospitalisation, including the need for ICU care, and deaths, especially for more vulnerable populations.

It also limits the number of people who will develop post-acute sequelae such as long COVID.

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

45. Evidence indicates that transmission increased by approximately 20% from mid-September to early November 2022, likely due to the changes in behaviour resulting from the removal of mandatory self-isolation for household contacts and mask wearing requirements in September 2022.

46. Modelling on current mandatory case isolation indicates that:

    a. if the current measures are retained, the daily hospital occupancy will reach between 250 to 300 beds occupied daily over the next two months

    b. a change in case isolation requirements that results in transmission increasing by 10% will cause an approximate 70% increase in peak bed occupancy in hospitals over the two months following the change (requiring around 150 - 175 extra beds to be occupied compared to status quo settings), with a disproportionate effect on vulnerable populations.

47. An increase of 10% in transmission is a plausible mid-point scenario, noting that the modelled is likely to underestimate impact of changes due to unmodelled behaviour changes. For comparison, an increase in transmission of 7.5%, will cause an approximate 50% increase in peak bed occupancy in hospitals in the two months following the change (requiring around 125-150 extra beds to be occupied compared to status quo settings).

48. Such predicted outcomes (in addition to the transmission change following September 2022 policy changes) as a result of any change to case isolation requirements, should be understood in light of the evidence that shows the removal of household contact isolation and mask wearing requirements in September 2022 resulted in a 20% increase in transmission which was double the initial modelled expectations.

49. This indicates that it is not prudent to underestimate current compliance to measures in the community due to a much higher increase in the rate of transmissions being observed following changes to quarantine measures from mandatory to guidance for household contacts.

Further details on adverse impact of transmission

Deaths attributable to COVID-19

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

Long COVID

51. The Director-General reports that based on evidence from overseas, 3-10% of cases may develop long COVID, of whom 20% may have ongoing significant disability. Long COVID and other post-acute conditions have costs to individuals and whānau, costs to government (welfare and health), but also broader impacts on society, such as reduced workforce participation and productivity.

Impact on ethnic groups

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

Older people

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

54. The number of people still completely susceptible to infection is approximately 800,000. Out of that 350,256 people are 70 years and older. Infections in this older age group are the main driver for hospitalizations.

55. Within the 70 years and older age group almost 60% of people are still susceptible to infection so the relaxation of rules will cause a higher impact in terms of hospitalisations, as a large majority of this group has not yet been infected with COVID-19.

56. Hospitalisations are primarily driven by infections in older age groups. It is important to delay infections in this group. Current settings and behaviours that are being observed are having an impact on reducing infections in this older age group.

57. Immunity in this group will rise slowly, via vaccination. Bivalent vaccines are planned to be rolled out, and allowing time for the roll-out, by preventing and delaying infections, will assist in achieving the objective of the immunisation programme (avoiding severe illness, hospitalisations, and deaths).

Reinfections

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

Hospitalisations

59. If mandatory self-isolation requirements were removed the increase in peak daily hospitalizations will be approximately 460 representing:

- 80% of third wave peak (December 2022)
- 50% of second wave peak (July 2022)

- 49% of first omicron wave (March 2022

60. Some 63% of COVID-19 hospitalisations are 'for COVID-19' meaning COVID infections cause a significant burden on the health system:

- hospitalizations are largely driven by the 70 years plus age group
- this cohort is large and susceptible
- flattening infections in this group requires delaying infections over time
- immunity profile in this group will improve as bivalent vaccines become available.

Summary

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

62. More information on the expected impacts and modelling can be viewed in the PHRA (see Annex 1).

Extension to Prime Minister Authorisation

63. The current Authorisation Notice expires on 28 February 2023

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

65. Following on from the public health risk assessment on 26 January 2023, and the advice to Ministers reflected in the Cabinet paper to be considered on 20 February, I suggest that the use of COVID-19 orders and associated measures should now be authorised for a further period of 2 months to support the COVID-19 response.

66. The Authorisation enables the use of these measures, but it does not require that they be used for the duration of the extension. The justification of using these measures is regularly assessed throughout the duration of the Authorisation, and changes will be made to the measures if they become inappropriate before the Authorisation expires.

67. The specific measures provided for under orders, and the public health justification for them, are discussed briefly below.

Self-isolation

Current provisions

68. Currently, the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 (the Self-isolation Order) requires COVID-19 cases who report their test results to self-isolate for 7 days. This requirement is qualified by provisions which enable cases to leave their place of self- isolation to carry out high priority activities under highly restrictive conditions. These conditions include strict infection prevention and control (IPC) measures.

69. Essential permitted movements comprise the main category of activity involved. These include movements which must be carried out for pressing reasons of health or mental well-being or because of a legal obligation. The Self-isolation Order also includes an exemption process to allow cases in critical roles to attend to work where there may otherwise be significant disruption to an essential service.

Rationale

70. Public health advice recommended that mandatory self-isolation for COVID-19 cases be retained:

    a. Isolation of cases significantly limits the transmission of COVID-19 by reducing the proportion of cases infecting others in the community.

    b. Without government-mandated isolation for cases, it is highly likely that adherence to guidance would be lower, resulting in an overall increase in transmission and case rates.

    c. Higher case rates would increase the risks of serious illness and hospitalisation for Māori, Pacific people, older people, and people with disabilities (among other higher risk groups) and increasing pressures on the health system.

71. Overseas evidence suggests that a legal requirement to isolate results in significantly greater adherence than a recommendation to isolate. Experience when other mandates (eg, masks) have been removed in Aotearoa New Zealand suggests that adherence to guidance is typically much lower than it is to mandates.

72. More information on the efficacy of mandatory self-isolation is available in paragraphs 26-32 of the Cabinet paper.

Effect of the self-isolation requirement – protective and supportive

73. Provisions in the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 that related to compulsory testing, disclosure, and monitoring (clauses 11 and 12) were revoked on 12 September 2022.

74. The current provisions are mandatory insofar as self-isolation applies to those who elect to test and who return a positive test result.

75. In this context, the mandatory requirement may be seen as protective and supportive for those who choose to do the right thing. If they test positive, they can go into self-isolation with additional assurance that:

    a. their jobs are not at risk (ie, they are legally required to self-isolate if they test positive)

    b. in some cases, they will not be without financial means during their period of self-isolation (eg, where they have used up all their sick leave, the Leave Support Scheme (LSS) provides them with up to $600 a week).

Further review

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

Point of care tests

Current provisions

77. The importation, manufacture, supply, sale, packaging, and use of point-of-care tests is regulated under the COVID-19 Public Health Response (Point-of-care Tests) Order 2021. The purpose of this order is to ensure that point-of-care tests that are relied on to establish whether a person is subject to mandatory self-isolation are accurate and reliable.

Rationale

78. It is appropriate to maintain the regulation of point-of-care testing as long as mandatory self-isolation requirements are in place.

Mask requirements

Current provisions

79. The COVID-19 Public Health Response (Masks) Order 2022 (the Masks Order) specifies that:

    a. face masks are legally required for visitors in a wide range of health service settings including primary care, urgent care, pharmacies, hospitals, aged residential care (ARC), disability-related residential care, allied health, and other health service settings

    b. there are exclusions for certain people, including: patients and people receiving residential care, health service staff, and visitors to specific health services (psychotherapy, counselling, mental health, and addiction services).

Rationale

80. Mask requirements ensure people who are at higher risk of severe infection can access health services without avoidable additional risk. A conservative estimate is that one in every 6 New Zealanders is at higher risk of severe illness if they contract COVID-19.

81. Removing mask mandates for visitors in hospitals may lead to an increase in cases of hospital-acquired COVID-19. Hospital-acquired COVID-19 infections are more likely to have poorer outcomes than community-acquired COVID-19 infections, based on evidence from Victoria, Australia. Possible links between visitors and hospital-acquired COVID-19 infections has been noted. Therefore, there is still value in trying to prevent infections. More information on the efficacy of mask wearing is available in the PHRA (see Annex 1).

Scope of authorisation

82. The scope of the authorisation proposed in this paper is self-isolation of cases, point of care tests regulation, and masks in healthcare settings.

83. This approach will empower the Minister of Health to make orders within that scope and to amend those orders. For example, if there are issues with the mask requirements in particular healthcare settings, the Minister of Health could make those amendments. However, the Minister of Health would not be able to expand the scope of the orders to include, for example, self-isolation of contacts or masks on public transport. Your further authorisation would be required.

Duration of authorisation

84. It is proposed that the current authorisation (which will expire on 28 February 2023) be revoked, and that a new authorisation be made authorising the use of COVID-19 orders for specific matters through to 28 April 2023. The effect of these two actions is to ensure there is sufficient authorisation to make limited-scope COVID-19 Orders through to the end of April 2023.

85. This authorisation period is appropriate given:

    a. the increased risk and likely consequences of an outbreak or spread of COVID-19 if the use of COVID-19 orders and associated matters were not authorised over that period and were not able to be maintained to support the COVID-19 response

    b. the next public health risk assessment in March 2023, and the associated review of public health measures, advice, and government decisions in the following weeks ensures that the measures remain under review and can be removed if deemed unjustified regardless of the authorisation period lasting until 28 April 2023.

86. Should the risks associated with the COVID-19 outbreak change materially (up or down) then Manatū Hauora would undertake an ad hoc PHRA to ensure the public health measures remain appropriate and proportionate to those risks.

87. More generally, as information on new variants comes to hand, Manatū Hauora will assess the likely health impact in the Aotearoa New Zealand context and the Director-General of Health will alert the Minister of Health if this assessment suggests severe adverse health outcomes are likely. Any future public health measures and associated legal bases (epidemic notice or authorisation under the Act) will be based on the public health advice and the COVID-19 context at the time.

Consultation

88. This briefing was prepared by Manatū Hauora. It was informed by public health advice provided by Manatū Hauora. The Crown Law Office has provided legal advice. The Ministry of Justice, The Treasury, Te Whatu Ora, Te Aka Whai Ora, and Whaikaha were provided a copy of the paper. The Department of the Prime Minister and Cabinet was informed.

Next steps

89. If you agree with the recommendations in this paper, I recommend you sign the attached Authorisation Notice after Cabinet decisions are made on 20 February 2023, ahead of the expiry of the current authorisation on 28 February 2023.

90. The authorisation for signature will cover, subject to Cabinet's decisions, the following public health measures:

    a. COVID-19 Public Health Response (Self-isolation Requirements) Order 2022
    b. COVID-19 Public Health Response (Point-of-care Tests) Order 2021
    c. COVID-19 Public Health Response (Masks) Order 2022.

91. Manatū Hauora will continue to review orders being maintained and be satisfied they continue to be an appropriate measure to address the risks of the outbreak or spread of COVID-19.

ANNEX 1

COVID-19 PUBLIC HEALTH RISK ASSESSMENT – 26 JANUARY 2023 (attached)

ANNEX 2

AMENDMENT OF COVID-19 PUBLIC HEALTH RESPONSE ACT 2020 (the Act)

Purpose

The COVID-19 Public Health Response (Extension of Act and Reduction of Powers) Amendment Act 2022 (the Amendment Act) amended the Act to provide for the ongoing management of COVID-19 by continuing the legislative powers needed to implement public health measures to support the COVID-19 response.

Policy changes

The Amendment Act:

- amended the repeal date so that the Act is repealed 2 years after the day of Royal assent of the Amendment Act
- removed the requirement for the House of Representatives to periodically resolve that the Act remain in force
- removed the power for the Director-General of Health to make COVID-19 orders
- limited the power for the Minister of Health to make COVID-19 orders to only include the following public health measures

Context	Public health measure
In the community	Self-isolation (for cases, household contacts, close contacts) and masks
Mandatory masks, self-isolation and certain requirements for travellers to Aotearoa New Zealand	• Mask use on inbound flights to Aotearoa New Zealand • Pre-departure and/or post arrival testing requirements • Requirement for airline or ship operators to take reasonable steps to ensure passengers comply with pre-departure travel requirements • Requirement not to board a flight to Aotearoa New Zealand while exhibiting COVID-19 symptoms or if under a public health order in another country or if currently positive for COVID-19 • Self-isolation and self-quarantine for people arriving from at risk countries (or potentially from anywhere) • Provision of travel history and contact information to support contact tracing

- limited enforcement powers by:

  - removing the power for warrantless entry to private dwellings and marae, the power to close roads and public places and stop vehicles, and the power to direct a person to produce evidence of compliance with a specified measure
  - specifying the types of enforcement officers that can be authorised by the Director-General of Health consistent with authorisations used to date
- reduced the maximum penalties for infringement offences and criminal offences
- delayed commencement of new penalty levels in order to allow time to amend penalties in the COVID-19 Public Health Response (Infringement Offences) Regulations 2021, and thereby ensure that penalties in those regulations remain consistent with the maximum infringement offence penalties in the Act
- repealed section 145 and Schedule 5 of the Residential Tenancies Act 1986, used to activate tenancy termination restrictions during lockdowns, because lockdowns will not be enabled by the Act
- removed all provisions relating to MIQFs, but included a transitional provision to preserve the ability to recover existing MIQF debts.

As amended, the Act retains its important safeguards such as the prerequisites for COVID-19 orders, and the requirement that all COVID-19 orders be consistent with the New Zealand Bill of Rights Act 1990.

Minister's Notes