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28 July 2023

§ 9(2)(a)

By email: § 9(2)(a)  
Ref: H2023023743

Tēnā koe § 9(2)(a)

### Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to Manatū Hauora (the Ministry of Health) on 17 April 2023. You requested:

*“Can you please as a matter of urgency provide all information relating to the [Mask] Order held by the Ministry of Health from 1 January 2023 to the date a response is provided, including all communications between the Ministry and health services that are subject to the Order, together with all briefing papers and communications with the Minister relating to the Order.”*

On 11 May 2023, your request was partially transferred to Te Whatu Ora – Health New Zealand under section 14(b)(ii) of the Act. Please refer to their response for information their agency holds in due course.

Manatū Hauora has identified six documents within the scope of your request. All documents are itemised in Appendix 1 and copies of the documents are enclosed. Where information is withheld under section 9 of the Act, I have considered the countervailing public interest in releasing information and consider that it does not outweigh the need to withhold at this time. We apologise for the delay in sending out your request.

On 27 June 2023 we advised you that we made a decision on your request and had initially identified 79 documents within scope of your request which needed further investigation. However, following further consideration of the material, the majority of this information has been deemed out of scope of your request for reasons such as being administrative emails.

I trust this information fulfils your request. If you wish to discuss any aspect of your request with us, including this decision, please feel free to contact the OIA Services Team on: [oiagr@health.govt.nz](mailto:oiagr@health.govt.nz).

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](mailto: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](http://www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests).

Nāku noa, nā

A handwritten signature in black ink, appearing to be 'A. Old', written in a cursive style.

Dr Andrew Old  
**Deputy Director-General**  
**Public Health Agency | Te Pou Hauora Tūmatanui**

## Appendix 1: List of documents for release

#	Date	Document details	Decision on release
1	26 January 2023	Memo: COVID-19 Public Health Risk Assessment – 26 January 2023	Some information withheld under the following sections of the Act: <ul style="list-style-type: none"> <li>• Section 9(2)(f)(iv) to maintain the constitutional conventions that protect the confidentiality of advice tendered by Ministers and officials; and</li> <li>• Section 9(2)(h) to maintain legal professional privilege.</li> </ul>
2	14 March 2023	PHRA Issue Paper: Review of mandatory COVID-19 measures for 16 March 2023 Public Health Risk Assessment: Mask Mandates in Healthcare Settings	Released in full.
3	16 March 2023	Memo: COVID-19 Public Health Risk Assessment – 16 March 2023	Some information withheld under the following sections of the Act: <ul style="list-style-type: none"> <li>• 9(2)(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers and officers and employees of any public service agency,</li> <li>• 9(2)(f)(iv); and</li> <li>• 9(2)(h).</li> </ul>
4	9 February 2023	Regulatory Impact Statement: Continuing with mandatory public health measures under the COVID-19 Public Health Response Act 2020	Refused in full under section 18(d) of the Act, as the information requested is soon to be publicly available at: <a href="http://www.health.govt.nz/about-ministry/information-releases/release-ministerial-decision-making-documents">www.health.govt.nz/about-ministry/information-releases/release-ministerial-decision-making-documents</a>
5	27 February 2023	Cabinet Social Wellbeing Committee Cabinet Paper: COVID-19 public health measures	<a href="http://www.health.govt.nz/about-ministry/information-releases/release-ministerial-decision-making-documents">www.health.govt.nz/about-ministry/information-releases/release-ministerial-decision-making-documents</a>
6	11 April 2023	Cabinet Social Wellbeing Committee Cabinet Paper: COVID-19 public health measures.	

# Memo

## COVID-19 Public Health Risk Assessment – 26 January 2023

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

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### Purpose of report

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

### Summary of Recommendations

2. The purpose of the COVID-19 PHRA is to assess the current and medium-term COVID-19 risk and to consider whether there needs to be any changes to the suite of public health measures to manage the risk. This can include recommendations to relax or escalate risk mitigation measures. In addition, the PHRA fulfils the legal requirement to keep mandatory measures (made via Orders) under regular review to ensure that they remain necessary and proportionate.
3. When combined, individual measures form a pragmatic approach to managing COVID-19. There are interdependencies between each, and we must remain aware of how they form a coherent package for the public to encourage and support public health behaviours necessary to reduce transmission and limit the impact of COVID-19.
4. The principle of proportionality is a key consideration. This principle requires that the least restrictive measures are used and for no longer than is necessary to achieve the objective of preventing, minimising, or managing the COVID-19 public health risk. In assessing proportionality, it is important to account for both Tiriti o Waitangi and equity considerations as more restrictive measures may be required to achieve these objectives.
5. The focus of the PHRA Committee meeting on 26 January was to assess the current public health risk arising from COVID-19 in Aotearoa New Zealand based on data and recent model outputs. The Committee did discuss all current mandates but rather than considering specific options for change identified specific issues requiring further analysis

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

### 1. Point of Care Testing Order

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

### 2. Face masks

<b>Current requirement</b>	<p>The COVID-19 Public Health Response (Masks) Order 2022 specifies that:</p> <ol style="list-style-type: none"> <li>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)</li> <li>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).</li> </ol>
<b>Director of Public Health recommendation</b>	<ol style="list-style-type: none"> <li>1. <b>Retain</b> the current face mask mandate in health service settings, while further work is undertaken before the next PHRA to consider whether the range of health service settings captured by the definition in the Order remains appropriate (with a specific focus on pharmacies and allied health settings).</li> <li>2. Previous advice recommended re-instating a requirement for masks on public transport. Given the current stage of the outbreak, with lower cases and system impacts than pre-Christmas, this requirement is no longer recommended although general advice to wear masks in closed, crowded and poorly ventilated spaces still applies.</li> </ol>

### 3. Case isolation

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

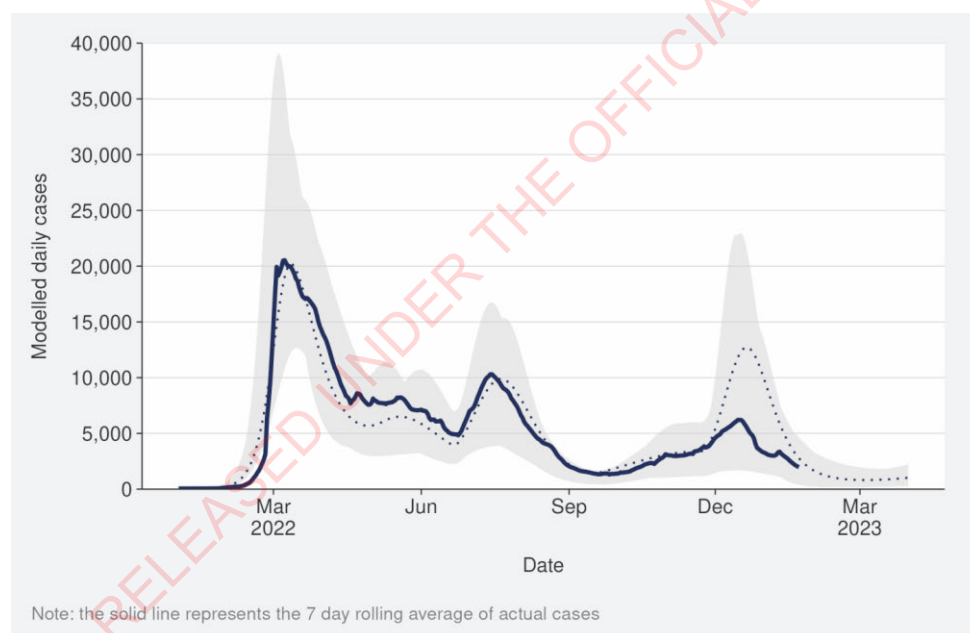
## Background and context

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

*COVID-19 cases and hospitalisations are trending downwards*

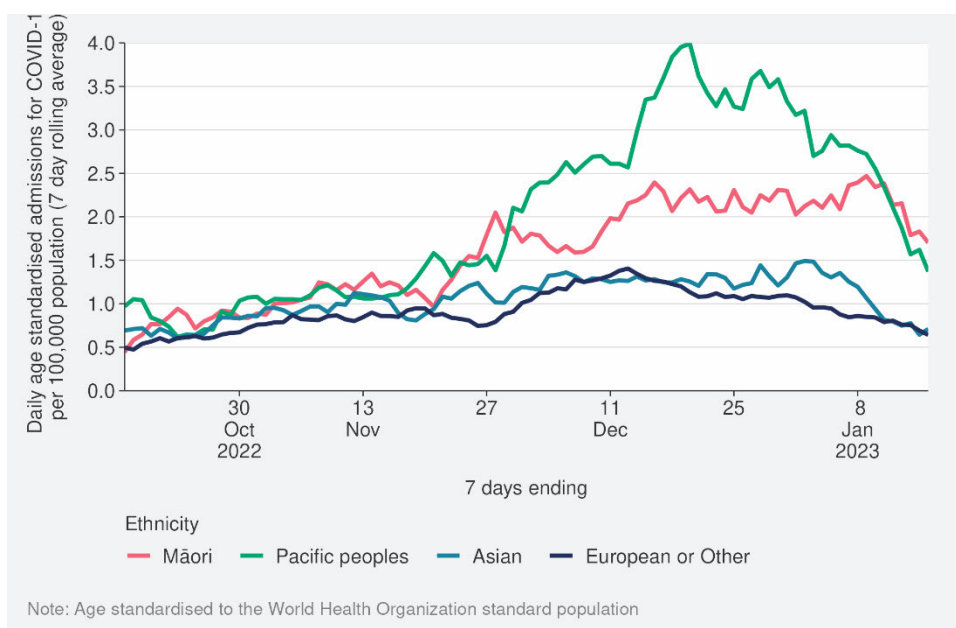
6. Overall, the key measures of infection (levels of viral RNA in wastewater and reported case rates) used to monitor the COVID-19 epidemic continue to decrease in most regions after peaking in mid-December 2022.
7. COVID-19 related hospital admission rates have also decreased since the start of 2023, while mortality counts are tracking well below the expected modelling. Hospitalisations that are classified as being 'for COVID-19' are higher than the incidental rate. Between 1 January and 16 January 63% of COVID-19 related hospital admissions were patients coming in for COVID-19 related illness rather than incidentally having COVID-19.
8. The lower-than-expected reported cases, hospitalisation and mortality rates may be, in part, due to a change in the public's behavioural patterns over the summer period. Cases may return to following the modelled range as people return to their usual habits and schools reopen. The committee noted that previous behavioural surveys have suggested a high proportion of positive cases report positive RAT results, but it is possible that reporting and testing behaviour also changed over the holidays. There was a large increase in reporting of positive RAT results in the 15 to 24 year age group in the second week of January. The increase could have resulted from social events over the New Year holiday, changes in testing and reporting or both factors. Further data on testing and reporting will be collected over the next few weeks.

Figure 1 - COVID-19 Modelling Aotearoa scenarios compared with national through 22 January 2023<sup>1</sup>



#### *Vulnerable populations have the highest rates of hospitalisation*

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



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

*There is a lower uptake of the second booster*

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

*There is currently no dominant variant in the community*

12. There is a range of variants in the community with no one variant being dominant. The most common variant is CH.1.1, which is a sub-lineage of BA.2.75, and now accounts for 34% of cases in the community. The next most prevalent are XBF at 19% of community cases, BA.2.75 at 17%, and BQ1.1 at 15%. BA.5 which was the dominant variant for most of 2022 has been steadily declining since November and now only accounts for 9% of the total cases.
13. XBB.1.5 (referred to as Kraken in the media) has not currently taken hold in New Zealand as it has in the United States (US). In the US we have seen XBB.1.5 demonstrate a growth advantage over other new variants and it is possible that this could become the new dominant strain of COVID-19 in New Zealand. It is notable that New Zealand has a different immune landscape to the US and so far, XBB (which XBB.1.5 is a subvariant) only accounts for 2% of total cases.
14. BF.7 is the leading variant emerging from China currently accounting for 33% of the total cases. This variant has been in New Zealand since October 2022 at low levels and does not appear to have a growth advantage over other variants.

*Update on actions following PHRA of 2 January 2023*

15. On 2 January 2023, a PHRA was carried out in response to growing case rates in China, and the emergence of XBB.1.5 in the United States. The purpose of the PHRA was to assess whether any change in settings was required in response to this international context.
16. The risk assessment determined that the risk posed by travellers from China entering New Zealand was minimal. Accordingly, the Committee advised against mandatory pre-departure or on-arrival testing of travellers from China. Instead, the Committee advised that operational changes were made to make information about testing more accessible to Chinese travellers, and that arriving travellers will be strongly encouraged to test voluntarily over a four-week period. This is a strictly time-bound programme of enhanced surveillance, which is not scalable or enduring.
17. Voluntary testing of a sample of passengers arriving on direct flights from China began on 20 January 2023. In the period 20 January to 26 January, 36% (353/970) of air border arrivals from China submitted a rapid antigen test (RAT). There were no reports of positive RATs.
18. In addition, officials from Manatū Hauora and Te Whatu Ora are continuing to work with ESR to further develop wastewater surveillance at airports, and potentially also from flights.
19. For the full context refer to the Manatū Hauora webpage, COVID-19 Trends and Insights which provides an interactive dashboard and regular analysis of the COVID-19 outbreak, including cases, hospital admissions and deaths.<sup>1</sup>

## Risk Assessment

### *Cases are declining*

20. The situation has improved since the last PHRA, with almost all indicators suggesting the public health risk posed by COVID-19 in Aotearoa New Zealand is low. Modelling undertaken in late 2022 suggests that this trend will continue, but the modelling does not factor in some context and influences, such as the possibility of new variants of concern, changes to vaccine eligibility or the use of antivirals.
21. As noted above, daily case numbers and hospital admissions are declining. Deaths have not climbed as high as was predicted pre-summer and have been relatively stable for the past few weeks.

### *Variants of concern*

22. Omicron sub-variant XBB.1.5 continues to make up small proportion of cases since it was detected in Aotearoa New Zealand in mid-December 2022. While U.S. data suggests that it has a growth advantage over other sub-variants, the immunity profile of the New Zealand population is different to that of the U.S. population so it is unclear how this sub-variant will affect New Zealanders.
23. As noted above, China is reporting a large increase in Omicron sub-variant BF.7 cases as they transition from a "Zero-COVID" policy toward less restrictive approach. But results from genomic testing in China has not detected any concerning mutations. Further, data suggests that BF.7 does not have a growth advantage in New Zealand.

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



### *Uptake of therapeutics*

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

### *Seasonal factors have influenced trends*

25. Cases tracked below expectations over the summer period. This is likely because of the behaviours and activity of people over this period. While there were high rates of domestic travel over the summer, activities taking place outdoors and away from education facilities and workplaces meant that transmission declined over this period.
26. This drop in case rates may also be partly due to the modelling not accounting for short-term changes in behaviour and because case ascertainment fluctuated over the summer. In particular with many people holidaying away from home, it is possible that people with symptoms were also less likely to test or report results.

### *Trends will be impacted by people returning to work and education*

27. As people return to indoors locations through work, school and university, mixing rates will increase and case rates are expected to decrease at a slower rate or increase for a short time before continuing to decrease. The timing of the next COVID-19 wave is uncertain but may well coincide with the beginning of the winter respiratory illness season. Factors influencing the timing will include the population level of hybrid immunity to current variants and immune evasiveness of variants that emerge over the next months.
28. The committee noted that in the second half of 2022 the Northern hemisphere observed an earlier-than-usual flu season, placing unexpected pressure on healthcare services.<sup>2 3</sup> This indicates some uncertainty around the timing of New Zealand's typical Winter flu season in 2023. If New Zealand observes a similar phenomenon, then the usual uptick in respiratory illnesses may begin as early as April 2023.

### *Director of Public Health Comment*

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

### *Proportionality of retaining the status quo*

30. The COVID-19 Public Health Response Act 2020 requires that the Government keeps Orders under regular review to ensure that any limitation they impose on rights or freedoms under the New Zealand Bill of Rights Act 1990 is justified and proportionate to the risk posed by COVID-19.
31. While daily case numbers and overall hospital admissions for COVID-19 are declining, and the overall uptake of antivirals is increasing, the risk posed by the virus to many groups within the population remains significant. Rates of COVID-19 mortality have been low and relatively stable for the past few weeks), the overall decline of case rates and hospitalisations may change as students and workers return to indoor areas, and uptake of

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

32. The requirement to isolate as a case is a significant imposition on a person's right to freedom of movement. The intention is to reduce onward transmission. Recent WHO patient management guidelines have noted that risks of transmission from asymptomatic cases are considerably lower than from those with symptoms. s 9(2)(f)(iv)

33. Enforcement of face mask requirements in non-hospital health settings such as pharmacies is challenging as it is not clear to pharmacy workers and customers who is considered a visitor who must wear a mask, and who is a patient (not required to wear a mask). The intended interpretation is that everyone who enters a pharmacy is required to wear a mask, but this requirement is rarely observed and is difficult to monitor and enforce.
34. Where the requirement is interpreted as intended, however, the mask requirement in pharmacies ensures that people who are at greater risk of severe illness from infection and who may be more likely to visit pharmacies, such as older or disabled people, are offered more protection when visiting pharmacies.

### The basis for retaining current measures within this context

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

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

36. Since the 26 January 2023 PHRA meeting, modelling has become available (and hence, it was not presented or discussed by Committee members) on how removing mandatory requirements and switching to guidance on measures relating to household contact isolation and mask wearing on 12 September 2022 may have impacted transmission. Modelling indicates that transmission increased by approximately 20% from mid-September to early November, likely due in part to the changes in behaviour resulting from the removal of mandatory measures. The expected increase in transmission prior to this switch to guidance was 8.5%, based on international evidence about levels of compliance under guidance.
37. Modelling on current mandatory case isolation indicates that:
- if the current measures are retained, the daily hospital occupancy will reach between 250 to 300 beds occupied daily over the next two months
  - a change to case isolation requirements that results in an increase in transmission of 7.5%, will cause an approximate 50% increase in peak bed occupancy in hospitals in the two months following the change (requiring around 125-150 extra beds to be occupied compared to status quo settings)
  - a change in case isolation requirements that results in transmission increasing by 10% will cause an approximate 70% increase in peak bed occupancy in

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

38. See Appendix 2 for assumptions and caveats of the modelling, and for graphs representing the scenarios outlined in paragraphs 30-37.
39. These predicted outcomes based on transmission increasing by 7.5% and 10% (in addition to the transmission change following September 2022 policy changes) as a result of any change to case isolation requirements, should be understood in light of the modelling that shows the removal of household contact isolation and mask wearing requirements in September 2022 resulted in a 20% increase in transmission.

*Case isolation is still considered to be an effective measure*

40. The rationale for continuing to require self-isolation is as follows:
- a. Isolation of cases remains the cornerstone of New Zealand's public health response to COVID-19. This measure significantly limits transmission of COVID-19 as it helps to break the chain of transmission by reducing the proportion of infectious people having contact with and infecting others in the community, many of whom may be at high risk of poor outcomes.
  - b. Without mandated case isolation, it is highly likely adherence to guidance would be lower, resulting in more infectious cases seeding community transmission and increasing overall case rates.
  - c. Overseas evidence suggests that a legal requirement to isolate results in significantly greater adherence than a recommendation to isolate. Experience when other mandates (eg masks) have been removed in New Zealand reinforces the fact that adherence to guidance is typically much lower than to mandates. However, given cases may be unwell from the symptoms of COVID-19, there may be a higher adherence to self-isolation guidance than for other measures.
  - d. Other infection control tools, such as requiring face masks or physical distancing are significantly less effective than isolation. We have been able to recommend removing or reducing some of those other tools in part because case isolation has remained in place. However, there is no combination of other mechanisms that would come close to producing the broad public health benefits provided by mandatory case self-isolation, including the minimisation of disruption to essential services caused by high transmission of COVID-19.
41. Advice from the 7 November 2022 PHRA continues to be relevant and has been added to Appendix 1 to ensure that this measure continues to be reviewed and monitored. This ensures that it remains a proportionate and effective at limiting the impact of COVID-19. Appendix 1 outlines the efficacy of mandated case isolation in comparison to voluntary (but encouraged) case isolation, emphasises the role that case isolation plays in an equitable health response to COVID-19 and notes that 7-day isolation is an appropriate duration for cases to isolate.

42. s 9(2)(f)(v)
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

*Face masks are also still considered to be an effective measure*

43. Evidence that wearing a face mask decreases the rate of COVID-19 community transmission (and other airborne respiratory viruses) is substantial (HR20221311 outlined the evidence base of their use and mandates). Overseas evidence suggests mandates increase adherence<sup>5</sup> are associated with reductions in COVID-19 case and mortality growth rates<sup>6 7 8 9</sup>, and the that the timing of when face mask mandates are applied matters - early application is associated with a reduction in cases and mortality rates.<sup>10</sup>
44. Face mask mandates lean against inequity, to ensure that people who are at higher risk can access basic services without avoidable additional risk. A conservative estimate is that one in every six New Zealanders is at higher risk of severe illness if they contract COVID-19.<sup>11</sup> Mandates have two benefits for this group of people: it means that they will be less likely to be infected, and be more likely to feel able to continue to safely participate in basic activities of life (for example accessing healthcare, visiting a pharmacy).

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

45. Health service settings have a series of characteristics that elevate the risk of transmission and/or the risk of severe disease. These settings and the services provided within these settings typically:
- 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
  - 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
  - have variable capacity to reduce crowding, indoor ventilation and/or air filtration<sup>12</sup>
46. People with hospital-acquired COVID-19 infections are more likely to have poorer outcomes than community acquired infections<sup>13</sup>. Feedback from two districts in late 2022 noted possible links between visitors and hospital-acquired cases of COVID-19. The need to access healthcare means people often do not have a choice in whether they access a health service.
47. While adherence to face mask requirements may be waning or patchy in some health service settings, adherence could drop further if the mandate was removed, as evidenced by the decreased use on public transport since the mandate was dropped in mid-September (but has remained recommended by Manatū Hauora).
48. Further work to be undertaken before the next PHRA includes a consideration of whether the range of health service settings captured by the definition in the Order remains appropriate (with a specific focus on pharmacies and allied health settings).

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

### **Impact of COVID-19 on vulnerable populations**

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

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

50. COVID-19 attributed mortality rates are also higher among Pasifika (2.1x higher) and Māori (1.7x higher), compared to European or Other ethnicities.
51. The most deprived populations continue to have the highest rates of hospitalisation (1.1 per 100,000), compared with those who are least deprived (0.8 per 100,000). There is also an increased risk of COVID-19 attributed mortality for those in socio-economically deprived groups. The most deprived 20% of the population have 3 times the risk of mortality when compared with those in the least deprived 20%.
52. Disabled people aged <65 years who receive Disability Support Services have a hospitalisation risk that is 4 times higher than the rest of the population. Further, rates of COVID-19 attributed mortality are 15 times higher among this group compared to the rest of the population.
53. Despite the lack of information on whether any changes would increase the disproportionate impact on these populations, Committee members emphasised that any reductions of public health measures will increase prevalence of Long COVID, and that this increased prevalence will disproportionately impact Māori Pacific Peoples and disabled people due to their vulnerability to infection. This is particularly concerning given that the criteria for diagnosing Long COVID and Long COVID support systems remain under development and given that these groups are more often under-diagnosed and under-treated when accessing healthcare.<sup>14 15 16 17 18 19</sup>

### Addressing equity concerns

54. There is an ongoing and strong concern among Committee members that a reduction in measures would put vulnerable populations at disproportionate risk. They emphasise that decisions to step down measures should not be made based on population-wide data and context, but rather on the data representing specific vulnerable groups such as disabled people, Māori and Pacific people, and older people.
55. In a Manatū Hauora survey conducted between 29 September and 9 October 2022, Māori health providers indicated that targeted Māori holistic immunisation programs and addressing the impacts of Long COVID were the areas of highest importance for them and their communities.
56. § 9(2)(f)(iv)  
[REDACTED] COVID-19 vaccination efforts and Māori COVID-19 communications have highlighted the importance of Māori leadership at all levels; putting equity at the centre of decision making; enabling providers to build relationships with communities; enabling communities to lead responses, and collaboration across agencies. It also notes the disproportionate risk that Māori face of getting Long COVID, and highlights how certain options would minimise this risk.
57. The increasing accessibility and uptake of antivirals for vulnerable populations is providing greater protection against the impact of infection. In the age bracket 50-64 years, antivirals have been provided to 55.89% of Māori cases and 41.96% of Pacific Peoples cases.

### Equity considerations in these recommendations

58. It is important that public health measures improve health equity and uphold Te Tiriti o Waitangi principles by protecting groups who are most vulnerable to COVID-19.
59. There was broad support among Committee members for retaining each of the existing mandated measures to protect vulnerable communities. While Manatū Hauora did not have data to support it, Committee members from Te Aka Whai Ora, Whaikaha and the Māori Health Agency expressed that the removal of other measures in recent months have already put these communities at greater risk.
60. Shifting mandatory case isolation to guidance is likely to disproportionately affect those who do not have the ability to choose to follow the guidance. This includes people in precarious employment, those unable to work from home, workers with limited sick leave and other vulnerable populations, particularly those with other socioeconomic disadvantages.
61. Committee members emphasised that any stepping down or removal of protective measures should be accompanied by specific alternative settings, modelling against those alternative settings, and extensive engagement with stakeholders from vulnerable groups prior to stepping down measures.
62. Stakeholders from the disability community have expressed concern that there is insufficient data on the impact that removing protective measures would have on disabled people. They argue that decision makers should consciously factor in this absence of evidence before making decisions that could profoundly impact disabled people.
63. If the COVID-19 situation significantly changes, enforceable or mandatory measures may be re-introduced to protect our vulnerable populations. This would be an effective and proportionate response to a worsening risk profile.

## **New Zealand Bill of Rights Act 1990 (NZBORA) – Crown Law advice (legally privileged)**

### *Case Isolation*

s 9(2)(h)



66. s 9(2)(f)(iv)

### Next steps

67. Pending your agreement, we will share this memo with the Minister of Health's Office and the Parliamentary Counsel Office.
68. On 9 February 2023, you will provide advice to the Minister of Health that draws on this memo and any additional information or advice you wish to include.
69. That PHRA and your subsequent advice to Minister of Health will then inform a Manatū Hauora-led Cabinet paper on that topic to be considered by Cabinet's Social Wellbeing Committee on 14 February 2023, and then Cabinet on 20 February 2023.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

## Recommendations

It is recommended that you:

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



Signature \_\_\_\_\_ Date: 31/01/2023

Dr Nicholas Jones

**Director of Public Health**

**Public Health Agency | Te Pou Hauora Tūmatanui**

**Manatū Hauora | Ministry of Health**



Signature \_\_\_\_\_

Date: 1 February 2023

Dr Diana Sarfati

**Director-General of Health | Te Tumu Whakarae mō te Hauora**

**Manatū Hauora | Ministry of Health**



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

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

### Purpose of self-isolation

3. A legal requirement to self-isolate remains the cornerstone of New Zealand's COVID-19 public health response. It significantly limits transmission of COVID-19 by breaking the chain of transmission by reducing the amount of infectious people having contact and infecting others within the community. In turn this limits hospitalisation, including the need for ICU care, and deaths, especially for more vulnerable populations. It also limits the number of people who will develop post-acute sequelae such as long COVID.
4. Without mandated case isolation and the associated support that it triggers, it is highly likely that adherence to guidance would be lower. This would lead to more infectious cases in the community, increasing overall case rates.

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

5. COVID-19 can have a wide variety of impacts on individuals. The majority of people infected will not need to go to hospital and will recover fully. However, a subset of people will have more significant health impacts – either in the acute or post-acute phases of the infection.
  - a. **Acute phase:** in reported cases to 22 January 2023, there have been 1,918,070 cases, of whom 25,673 (1.3%) were hospitalised, of whom 683 (2.7%) have required ICU care. There have been 3,754 deaths. Older people have substantially higher hospitalisation rates and, within each age group, Māori and Pacific communities, and people with disabilities have higher hospitalisation rates.<sup>20</sup>
  - b. **Post-acute phase:** each new infection (or reinfection) effectively 'rolls the dice' for one or more post-acute sequelae. The rate and severity of post-acute sequelae, in combination with an expectation of multiple waves a year with the potential for reinfection make the impact more significant than other post-viral conditions. Post-acute sequelae include:
    - i. Increased risk factors for a range of other health conditions: eg. cardiovascular disease<sup>21</sup>, neurologic and psychiatric disorders<sup>22</sup>, changes in brain structure<sup>23</sup>, immune dysfunction<sup>24</sup>, and diabetes.<sup>25</sup>
    - ii. Long COVID<sup>26</sup>: based on evidence from overseas, 3-10% of cases are likely to develop long COVID, of whom 20% will have ongoing significant disability.<sup>27</sup> While these figures may appear low, in the context of two-to-three waves each year, each with the possibility of reinfection with each new variant or subvariant, over time the longer-term disability and productivity impacts will become as or more significant as the acute impacts on individuals and the health system.
    - iii. Broader impacts: Long COVID and other post-acute sequelae have personal costs, costs to government (welfare and health), but also broader impacts on society<sup>28</sup>, such as reduced workforce participation<sup>29</sup> <sup>30</sup> and productivity.

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

6. Currently available vaccinations are protective against risk of severe disease (hospitalisation or death), and somewhat decrease the risk of infection and overall transmission in the community; less so for onwards transmission (ie transmission from an already infected person to another person).<sup>31</sup> But all levels of protection wane over time.
7. Antivirals also reduce the likelihood progression to severe disease, particularly for people at higher risk.<sup>32</sup> However, access to antivirals is currently limited, they must be taken within the first five days of symptoms, and they are contraindicated for people taking certain other medications.<sup>33</sup>
8. As outlined above, while to date we have been focused on the impacts during the acute phase (decreasing risk of severe harm), there is also health impacts in the post-acute phase. Most people who have post-acute sequelae will have had a mild acute case.

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

9. Typically, a person will have some degree of protection from reinfection in the first month post-infection<sup>34</sup>, however this protection is largely limited to reinfection with the same variant, and wanes over time. Reinfection is far more likely with a variant that is different to the one responsible for prior infections.
10. The planning assumption going forward is that New Zealand is likely to experience a minimum of two or more waves each year, until a sterilising vaccine can be developed.

*Comparison to other infectious diseases*

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

*Removing case isolation and associated support would increase health inequities*

12. It is likely that the increase in community cases would affect some communities and population groups more than others. Specifically:
  - a. There is an acknowledged differential exposure to COVID-19 risk related to socioeconomic status. People in lower socioeconomic groups are more likely to work in jobs with greater risk of exposure, to live in larger and typically more crowded houses, and to have underlying risk factors. If there are more infectious people circulating in a community with more baseline contacts, this increases the likelihood of onward transmission.
  - b. People who are socioeconomically deprived are more likely to face challenges in being able to isolate compared to people with greater access to socioeconomic benefits. This includes differing access to sick leave, income loss, and potential pressure from employers to return to work. Earlier return to work comes at the cost of increasing transmission, which is likely a more significant effect on health outcomes and ability to work due to illness.
  - c. As a result, people who experience higher levels of socioeconomic deprivation may be more likely to not test, not report results, or break isolation, potentially causing further cases and further inequities.

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

*Recent feedback from sector stakeholders echoed many of the concerns above*

13. *Compromising equity aims* – the Leave Support Scheme (LSS) is closely tied to isolation mandates. Loss of the LSS would present risks for vulnerable populations and workforces with fewer protections.
14. Coercion to return to work particularly for the most vulnerable – strong concern was expressed that if the isolation mandate was removed, employees may be pressured to return to work even if not fully recovered. Equity concerns were central to this feedback, particularly what this change might mean for Māori and Pacific communities.
15. Increased transmission because of relaxed requirements – removing the isolation mandate will almost certainly result in increased transmission, due in part to the message it sends regarding the importance of isolation and because of the inability of people to isolate due to the two factors above. Again, equity concerns were raised as any increase in cases will impact the priority populations most.

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

16. Based on available information, the requirement for self-isolation is having a strongly positive impact on reducing community transmission.
17. Rapid antigen tests (RATs) are currently New Zealand's primary testing tool for people with COVID-19 symptoms or household contacts. RATs are very effective at identifying people who are infectious, which is the most critical factor for isolation.<sup>35</sup> Under the current evaluation framework, all point-of-care tests permitted in New Zealand must have a minimum of 80% sensitivity and greater than 98% specificity (or a minimum of 90% sensitivity for Ct values less than 25).
  - a. Surveys have shown that people remain aware of the importance of isolating, and are willing to do so.
  - b. In July 2022, 88% of people surveyed indicated they were willing to isolate if they had COVID-19, were symptomatic, or if a household member tested positive.<sup>36</sup>
  - c. In an online survey of 1,505 adults undertaken 15-20 September 2022, preliminary data received on 11 October 2022 shows 8% of participants had tested positive for COVID-19 in the past two weeks and 9% of participants were self-isolating in the same two-week period.

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

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

19. Experience when other mandates have been dropped in New Zealand reinforces the fact that adherence to guidance is typically much lower than to mandates:
  - a. Face masks on public transport – there was a noticeable decrease in the proportion of people masking when it shifted from a requirement to a recommendation.
  - b. Face masks in schools – similarly, when masks were dropped as legal requirement in schools, (but remained as a recommendation) many Boards of Trustees opted not to require ongoing making.
20. Data insights produced 27 January 2023 show that changes in behaviour caused transmission to increase by 20%, likely as a direct result of the removal of certain mandatory mask-wearing requirements and the removal of household contact isolation requirements, in favour of guidance, on 12 September 2022.

### **Self-isolation requirements remain the most effective tool**

21. While there has been a reduction of isolation requirements over the course of the outbreak, we have reached what is probably the minimum threshold for self-isolation to remain an effective intervention.
22. As described above, the experience when other jurisdictions have shifted from mandated isolation to guidance for isolation, adherence has dropped significantly. Similarly, when mask mandates for schools and public transport were shifted to guidance, again, there was a significant, and sustained drop in use of these public health protections.
23. Other control tools, (eg. face masks or physical distancing) are significantly less effective than isolation. Also, we note that to be effective these tools are most effective when utilised across the entire population. We note it is important to see these tools as a suite of protections that work together. Each tool can be dialled up or down. We have been able to recommend removing or reducing some of those other tools in part because isolation has remained in place. However, there is no combination of other mechanisms that would replicate the public health benefit required self-isolation provides.

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

24. Modelling undertaken by CMA in September suggested that the current mandatory isolation policy is approximately preventing 450 hospitalisations and 50 deaths in the short term compared to guidance with a reduction to 5 days. Over a year, it is estimated to prevent 1000 hospitalisations and 300 deaths. This modelling was conducted prior to the emergence of the variants of concern mentioned in the outbreak status section, so should be interpreted as a minimum estimate.
25. When current settings are compared to mandatory with test to release from 5 days, the model estimates current settings are preventing 40 hospitalisations and 50 deaths in the short term. Over a year, it is estimated to prevent 250 hospitalisations and 30 deaths.
26. Accurate domestic data on the behavioural impact of shifting from mandatory isolation to guidance is lacking. However, data from the UK infection survey (based on adherence rates to guidance in the UK) suggests potentially larger increases in cases and hospitalisations from such a change.

27. Key limitations of the isolation model are that it assumes RAT sensitivity to be constant over the duration of illness and does not account for increased sensitivity at day 5. This means that the proportion of cases released who are infectious may be overestimated. Another limitation is that incomplete isolation under mandatory requirements is not fully accounted for. Both limitations would tend to overestimate the magnitude of increase associated with changes to the status quo. Furthermore, the modelling does not account for a new variant which could substantially increase infections.
28. In the PHRA of 22 November 2022, 5-day self-isolation plus test to release was also reviewed as an option to, in some cases, reduce the length of time people would isolate. Key concerns noted with this proposal at that time remain relevant:
- Most people would still be infectious upon release, leading to further seeding of cases in the community.
  - A partial change creates uncertainty to the public on when to isolate and many might view the isolation period as just 5 days.
  - People, especially in lower income areas, may be pressured to return to work after 5 days and not 7. Even when testing negative many people are still symptomatic on day 5. Further, going back to work early can result in a longer recovery period.
  - While the relaxing of settings will reduce the time spent in isolation it will increase the number of infectious people in the community. With cases currently rising it is not an appropriate time to relax measures. Operationally this will put further stress on the health care system.
  - Any increase in COVID-19 infections will have a disproportionate effect on the most vulnerable communities.
  - There is not equitable access to RATs. A test to release programme requirement will only benefit those who can easily access RATs
29. It was noted that further change, such as the introduction 5-day self-isolation plus test to release, is likely to create additional uncertainty and confusion.
30. People are more likely to adhere if isolation is mandatory. However, we have no accurate estimate of the proportion of people following the mandatory required. Behavioural data indicate 88% of those surveyed (July 2022) would follow isolation rules if they tested positive. Operational providers have reported that they believe the most critical factor is not whether isolation is mandatory or recommended, but rather whether people are adequately supported to do so.
31. Detailed modelling results were provided in the PHRA of 3 October 2022.

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

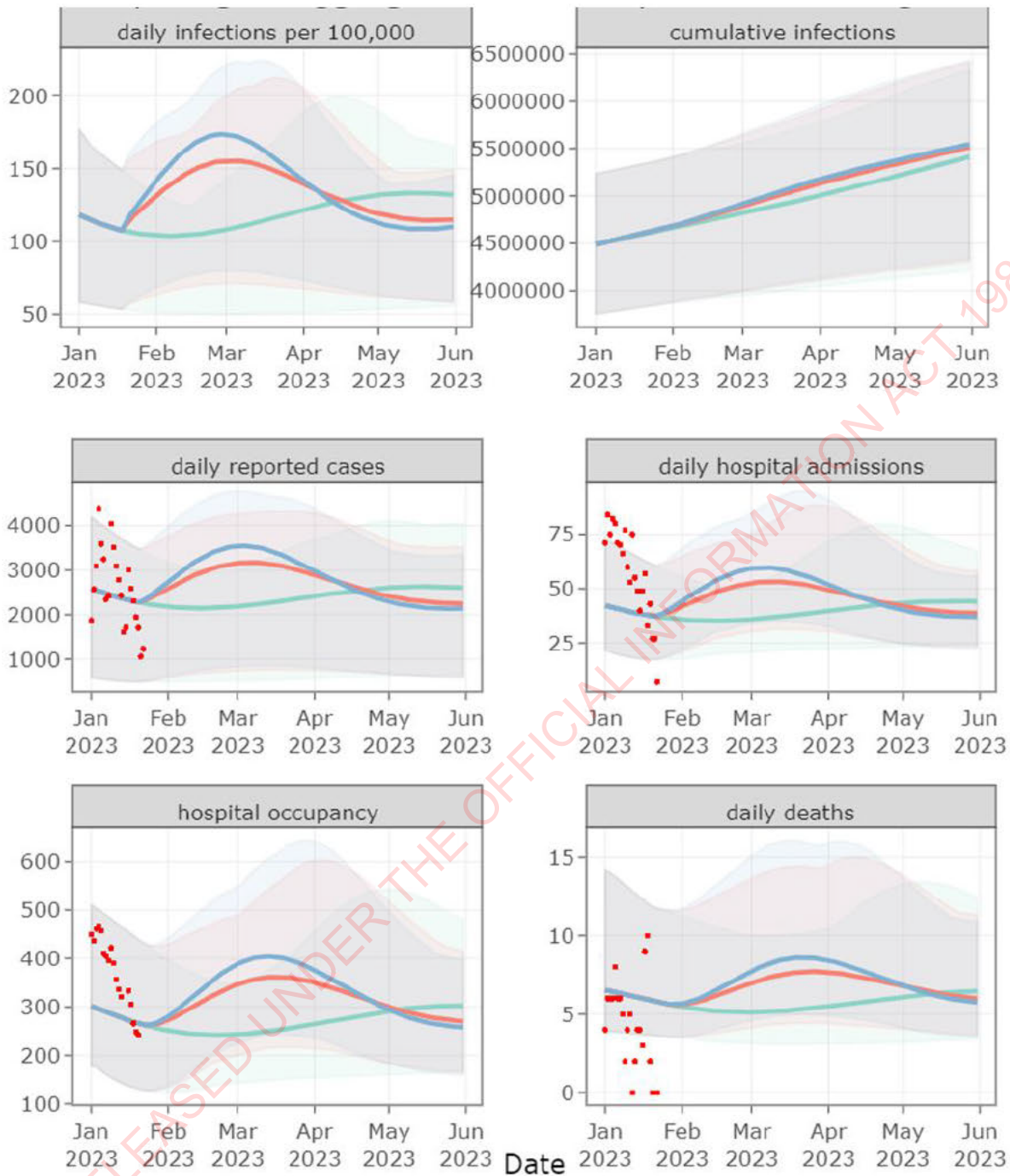
### *Assumptions and caveats*

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

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

33. There are a number of complex factors that influence the reproduction number  $R_t$ , including introduction of new variants with different levels of infectivity, changing travel patterns, increasing numbers of large community events, and reduced case ascertainment and contact tracing. These are not captured in current modelling.
34. **Case isolation assumptions:** With mandated 7-day isolation, it is assumed that 90% of transmission for identified cases is prevented.
35. **Long-term trajectory assumptions:** The model assumes BA.5 and the previous mix of variants is the prevalent variant landscape for the next 12 months and no changes to vaccination eligibility (e.g. third boosters, second boosters for more groups) and no change in available therapeutics.
36. **The model assumes no new variants occurring in the future:** Beyond November, simulations do not account for new variants of concern or their potential impact on cases, hospitalisations and deaths.
37. **Peaks and troughs assumptions:** Because this is a single national model, it may not capture the different size, shape and timing of peaks at a district or regional level. Therefore, the model may overestimate peaks and underestimate troughs, if outbreaks in different population groups are not aligned.
38. **Uncertainty around modelled estimates:** The provides credible intervals around estimates of cases, hospitalisations and deaths. This range reflects unknowns such as the share of infections detected and the speed of waning immunity. The model is fit to data up to 15 November 2022, which reduces some of this uncertainty.
39. **Uncertainty around “guidance” vs “requirements”:** It is difficult to say what model parameters to use to model the difference between mandates and guidance. Compliance and behaviours under a ‘guidance’ scenario will depend not only on what level people are inclined to follow guidance but also the level of communication around guidance. The model assumes the effect of guidance was an 8.5% increase in transmission, but observation of case data indicated it was a 20% increase. While modellers do not know what will happen in the future, they have empirical evidence that shows that switching to guidance had a much bigger impact than anticipated in the past, and we can quantify that it was approximately 2 times higher than initial assumptions.

Comparison of all aggregated metrics by scenario through time



**Scenario**

- noNov22VOC\_+0.0%\_20Jan
- noNov22VOC\_+7.5%\_20Jan
- noNov22VOC\_+10.0%\_20Jan

## Endnotes

- <sup>1</sup> COVID-19 Modelling Aotearoa, ordinary differential equation model, December 2022
- <sup>2</sup> <https://www.who.int/europe/news/item/01-12-2022-joint-statement---influenza-season-epidemic-kicks-off-early-in-europe-as-concerns-over-rsv-rise-and-covid-19-is-still-a-threat>
- <sup>3</sup> <https://www.cdc.gov/flu/spotlights/2022-2023/early-flu-activity.htm>
- <sup>4</sup> <https://www.who.int/news/item/13-01-2023-who-updates-covid-19-guidelines-on-masks--treatments-and-patient-care>
- <sup>5</sup> Adjodah D, Dinakar K, Chinazzi M, Fraiberger SP, Pentland A, Bates S, et al. (2021) Association between COVID-19 outcomes and mask mandates, adherence, and attitudes. *PLoS ONE* 16(6): e0252315. <https://doi.org/10.1371/journal.pone.0252315>
- <sup>6</sup> Guy GP Jr., Lee FC, Sunshine G, et al. Association of State-Issued Mask Mandates and Allowing On-Premises Restaurant Dining with County-Level COVID-19 Case and Death Growth Rates — United States, March 1–December 31, 2020. *MMWR Morb Mortal Wkly Rep* 2021;70:350–354.
- <sup>7</sup> Adjodah D, Dinakar K, Chinazzi M, Fraiberger SP, Pentland A, Bates S, et al. (2021) Association between COVID-19 outcomes and mask mandates, adherence, and attitudes. *PLoS ONE* 16(6): e0252315. <https://doi.org/10.1371/journal.pone.0252315>
- <sup>8</sup> Mitze, T., Kosfeld, R., Rode, J., & Wälde, K. (2020). Face masks considerably reduce COVID-19 cases in Germany. *Proceedings of the National Academy of Sciences of the United States of America*, 117(51), 32293–32301. <https://doi.org/10.1073/pnas.2015954117>
- <sup>9</sup> oo, H., Miller, G. F., Sunshine, G., Gakh, M., Pike, J., Havers, F. P., Kim, L., Weber, R., Dugmeoglu, S., Watson, C., & Coronado, F. (2021). Decline in COVID-19 Hospitalization Growth Rates Associated with Statewide Mask Mandates, March–October 2020. *Morbidity and mortality weekly report*, 70(6), 212–216.
- <sup>10</sup> Wong, Angus K.; Balzer, Laura B. State-Level Masking Mandates and COVID-19 Outcomes in the United States: A Demonstration of the Causal Roadmap. *Epidemiology: March 2022 - Volume 33 - Issue 2 - p 228-236* doi: 10.1097/EDE.0000000000001453
- <sup>11</sup> The Ministry of Health does not have precise figures for the number of New Zealanders who meet the definition of being at higher risk. However, in April 2022, the number of 'clinically vulnerable' people (which is defined more narrowly than 'high risk') was estimated at 800,000. 'Options for improving respiratory protection against aerosolised viral particles for vulnerable and priority populations' (HR20220682), 29 April 2022.
- <sup>12</sup> Many health service settings do not have good design or engineering. Therefore, the value of face masks to protect those more vulnerable increases when there is frequent introduction of infection into those environments. This is true of community healthcare settings, but also is an issue in many hospitals as older wards are mostly multibed rooms (eg. 4-6), have shared bathrooms and no doors on rooms, making it hard to isolate and improve air filtration.
- <sup>13</sup> 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.
- <sup>14</sup> Bhat, S, et al. 2022. *Ethnic Disparities in CT Aortography Use for Diagnosing Acute Aortic Syndrome*. *Radiology: Cardiothoracic Imaging*. Vol 4, No 6.
- <sup>15</sup> Lee, C, Duck, I, Sibley, C. 2017. *Ethnic inequality in diagnosis with depression and anxiety disorders*. *The New Zealand Medical Journal*. Vol 130, No 1454.
- <sup>16</sup> Ataoto-Carr, P, et al. 2008. *Rheumatic fever diagnosis, management, and secondary prevention: a New Zealand guideline*. *The New Zealand Medical Journal*. Vol 121, No 1271.
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- <sup>19</sup> Wilson, D, Haire A. 1990. *Health Care Screening for people with mental handicap living in the community*. *British Medical Journal*, 301, 1379-1381.
- <sup>20</sup> <https://www.health.govt.nz/publication/covid-19-mortality-aotearoa-new-zealand-inequities-risk>
- <sup>21</sup> Xie, Y., Xu, E., Bowe, B. et al. Long-term cardiovascular outcomes of COVID-19. *Nat Med* 28, 583–590 (2022). <https://doi.org/10.1038/s41591-022-01689-3>
- <sup>22</sup> Taquet M, Sillett R, Zhu L, et al. Neurological and psychiatric risk trajectories after SARS-CoV-2 infection: an analysis of 2-year retrospective cohort studies including 1 284 437 patients. *Lancet Psychiatry* 2022. doi:10.1016/S2215-0366(22)00260-7
- <sup>23</sup> Douaud, G., Lee, S., Alfaro-Almagro, F. et al. SARS-CoV-2 is associated with changes in brain structure in UK Biobank. *Nature* 604, 697–707 (2022). <https://doi.org/10.1038/s41586-022-04569-5>
- <sup>24</sup> Phetsouphanh, C., Darley, D.R., Wilson, D.B. et al. Immunological dysfunction persists for 8 months following initial mild-to-moderate SARS-CoV-2 infection. *Nat Immunol* 23, 210–216 (2022). <https://doi.org/10.1038/s41590-021-01113-x>
- <sup>25</sup> Xie, Y. & Al-Aly, Z. *Lancet Diabetes Endocrinol*. [https://doi.org/10.1016/S2213-8587\(22\)00044-4](https://doi.org/10.1016/S2213-8587(22)00044-4) (2022).
- <sup>26</sup> Davis, H.E., McCorkell, L., Vogel, J.M. et al. Long COVID: major findings, mechanisms and recommendations. *Nat Rev Microbiol* (2023). <https://doi.org/10.1038/s41579-022-00846-2>
- <sup>27</sup> <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19latestinsights/infections>
- <sup>28</sup> Cutler DM. The Costs of Long COVID. *JAMA Health Forum*. 2022;3(5):e221809. doi:10.1001/jamahealthforum.2022.1809
- <sup>29</sup> For example, a November 2022 report from the Office for National Statistics in the UK estimated that 2.1 million people living in private households (3.3% of the population) were experiencing self-reported long COVID (symptoms continuing for more than four weeks after the first suspected COVID-19 infection that were not explained by something else) as at 1 October 2022. See <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19latestinsights/infections>
- <sup>30</sup> <https://www.brookings.edu/research/new-data-shows-long-covid-is-keeping-as-many-as-4-million-people-out-of-work/>
- <sup>31</sup> Lin D-Y, Gu Y, Wheeler B, et al. Effectiveness of COVID-19 vaccines over a 9-month period in North Carolina. *N Engl J Med*. 2022. <https://doi.org/10.1056/nejmoa2117128>.
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- <sup>33</sup> <https://pharmac.govt.nz/news-and-resources/covid19/access-criteria-for-covid-19-medicines/covid-antivirals/>
- <sup>34</sup> <https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-health-advice-public/about-covid-19/getting-reinfected-covid-19>
- <sup>35</sup> Routsias, J.G., Mavrouli, M., Tsoplou, P. et al. Diagnostic performance of rapid antigen tests (RATs) for SARS-CoV-2 and their efficacy in monitoring the infectiousness of COVID-19 patients. *Sci Rep* 11, 22863 (2021). <https://doi.org/10.1038/s41598-021-02197-z>
- <sup>36</sup> The Research Agency (TRA). *July 2022 DPMC Behaviour & Sentiment Topline*.
- <sup>37</sup> Phetsouphanh, C., Darley, D.R., Wilson, D.B. et al. Immunological dysfunction persists for 8 months following initial mild-to-moderate SARS-CoV-2 infection. *Nat Immunol* 23, 210–216 (2022). <https://doi.org/10.1038/s41590-021-01113-x>
- <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandselfisolationaftertestingpositiveinengland/17to26march2022>



# PHRA Issue Paper

## Review of mandatory COVID-19 measures for 16 March 2023 Public Health Risk Assessment: Mask Mandates in Healthcare Settings

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**Date:** 14 March 2023

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**To:** PHRA Committee

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**From:** Dr Nicholas Jones, Director of Public Health

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**For your:** Information

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### Purpose of report

1. This memo provides you with background information and an assessment of options in relation to the mask mandate for visitors to healthcare settings. This information is to support discussion at the Public Health Risk Assessment (PHRA) meeting scheduled for 16 March 2023.

### Director of Public Health recommendation

2. I recommend that the visitor mask mandate be replaced with a facility-based approach that allows healthcare providers to require mask use according to their own health and safety policies that are in turn informed by national guidance. For Te Whatu Ora owned or contracted services guidance should be provided by a national Infection Prevention and Control expert advisory body and informed by current epidemiological conditions at the district level.

### Background

3. On 12 September 2022, Cabinet agreed to modify the Government's approach to managing COVID-19 considering the changing epidemiological context. Face mask requirements were limited to only visitors in health care settings This was enacted via a new COVID-19 Public Health Response (Masks) Order 2022 (Mask Order).
4. The Mask Order specifies that:
  - a. face masks are legally required for visitors<sup>1</sup> 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 (see Appendix 1 for the complete list).

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<sup>1</sup> COVID-19 Public Health Response (Masks) Order 2022, section 5(1)(a): "A person must wear a mask when they are at the premises of a health service unless the person is a patient or worker of the health service".

- 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).<sup>2</sup>
5. Face mask requirements for patients and workers of health services are determined locally, based on local assessments in line with Infection Prevention and Control (IPC) Guidance.
6. Public health messaging still emphasises that face masks remain an important defence against COVID-19. Manatū Hauora, Te Whatu Ora and the Unite Against COVID-19 websites set out the places, people and situations where a face mask is encouraged or strongly encouraged (see Appendix 2).
7. The most recent PHRA on 26 January 2023 reviewed the mask mandates, and no change was recommended.

## Options for mandated settings in the Mask Order

### Option 1: Retain the existing mask mandate in healthcare settings

This measure primarily seeks to protect those who are most vulnerable to severe outcomes from COVID-19 while community transmission is still present.

*Health care settings are uniquely high risk.*

8. Health service settings have a series of characteristics that make them high risk, which have justified the continuation of the mask mandates in these settings to date. 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 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 ability to improve crowding, indoor ventilation and/or air filtration<sup>3</sup>.
9. Hospital-acquired COVID-19 infections are more likely to have poorer outcomes than community-acquired infections - feedback from two districts has noted possible links between visitors and hospital-acquired cases of COVID-19. Furthermore, people often do not have a choice in whether they access a health service.

*Mask wearing is an important measure in reducing the spread of COVID-19.*

10. Mask wearing continues to be an effective measure in decreasing the rate of transmission of COVID-19<sup>4</sup>. While adherence to mask requirements appears to be waning or is patchy in some health service settings such as pharmacies, depending on the public messaging,

<sup>2</sup> Further details on the current settings can be found on the te whatu ora website at <https://www.tewhatuora.govt.nz/for-the-health-sector/covid-19-information-for-health-professionals/covid-19-information-for-all-health-professionals/covid-19-infection-prevention-and-control-recommendations-for-health-and-disability-care-workers/mask-wearing-healthcare-settings/>

<sup>3</sup> Many health service settings do not have good design or engineering. Therefore, the value of face masks to protect those more vulnerable increases when there is frequent introduction of infection into those environments. This is true of community healthcare settings, but also is an issue in many hospitals as older wards are mostly multibed rooms (eg. 4-6), have shared bathrooms and no doors on rooms, making it hard to isolate and improve air filtration.

<sup>4</sup> Briefing HR20221311 outlines the evidence base in relation to face mask use, and face mask mandates

removing the mandates may see lower use of masks in healthcare settings. Future mask adherence can't be predicted but we have seen a 10-15% drop in mask usage when removing mandates in other settings.

11. With winter approaching we can expect healthcare providers to be busier with vaccinations, seasonal illnesses, and dealing with surges of COVID-19. With increased activity it is even more important that healthcare services take necessary steps to protect patients and staff.

*Maintaining the mandate will require the Prime Ministers authorisation*

12. To maintain or modify the current mask settings will require an extension to the Prime Minister Authorisation under section 8(c) of the COVID-19 Public Health Response Act. The current authorisation is due to expire April 28 2023.

## **Option 2: Remove the Mask Order**

*Removing mandates makes healthcare providers solely responsible for managing masking*

13. The alternate option is to remove the Mask Order and 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. The risks laid out in Paragraph 7 predate COVID-19, with healthcare providers having thorough procedures in place to manage the spread of infectious disease through their facilities.
14. 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. When the issue was raised with the COVID-19 Vaccine Technical Advisory Group (CVTAG) they emphasised that replacing the mask mandates would allow healthcare providers to make mask policies consistent across the facility and ensure IPC measures remain proportionate to the risks.
15. Crucially, mitigation measures for COVID-19 will differ greatly from setting to setting and at different points in time. A bone marrow transplant unit will require different IPC precautions to ARC facilities which would be different again to allied health facilities and so on. The current mandates hold all healthcare settings to the same requirement regardless of the risk profile, the type of facility or needs of the community.

*Mask mandates can have adverse effects for some people*

16. There is also a major difference in the length of time a person might be in a healthcare setting where the mask mandate is applied, ranging from a brief appointment to being full time resident.
17. For full time residents in ARC facilities, the mask mandate can have significant impacts. For this group the health care setting is their home, and they often can have mobility issues which can make it difficult to leave the facility. The mask mandate means that all visitors to their home must wear face masks for the duration of the visit. There can be further complications depending on the health of the individual, such as residents with dementia finding masks disorientating, while for hard of hearing residents it is a barrier to communicate and can be very isolating.

18. As a result, Care Association New Zealand (CANZ), New Zealand Aged Care Association (NZACA) and the NZACA Nursing Leadership Group wrote to the Director-General of Health on 10 March 2023 (Appendix 3) requesting that ARC facilities be able to implement their own requirements to manage COVID-19. This letter outlines their ability to implement their own measures based on the community risk at the time and their health and safety policies and experience in managing disease outbreaks.

*The mandates are hard to enforce and compliance hard to measure*

19. The mask mandate specifically excludes staff and patients in healthcare settings. This along with the broad collection of services covered under the healthcare mandate, creates confusion to the public about when and where masks are required.
20. For example, the mandate applies to visitors to pharmacies, who are not there for healthcare reasons (e.g., not picking up a prescription or buying a health care product). Differentiating a 'visitor' from a 'patient' in these facilities is difficult and makes mask messaging and enforcement particularly challenging. Furthermore, it is arguable whether the actual benefit of the mask mandate is being realised in these setting (i.e., protecting those most at risk by reducing transmission) when the mandate applies to such a small proportion of people within the pharmacy at any given time.
21. Currently there is very little public communications on mask requirement informing visitors that they are legally required to wear a mask and enforcement of the mandates is left to staff on the ground. This creates variability between sectors and facilities with how the mandate is interpreted and enforced.
22. We are unable to get reliable data on the compliance of the current mandates, though the anecdotal view is there is a wide variance based on the risk perception of the healthcare service.

*Effective guidance and communications can be tailored to suit key settings*

23. If the mask mandates were removed Te Whatu Ora would need to continue to provide up to date IPC guidance for healthcare settings to base their procedures around. Furthermore, it would enable more broad public messaging about the value of masks for high-risk settings, particularly when community transmission risk escalates.
24. The potentially complex communications is another factor in not recommending any further narrowing of those currently required to wear a mask in a healthcare setting.

## **Equity**

*COVID-19 and the measures to manage it has exacerbated pre-existing inequities*

25. COVID-19 continues to worsen pre-existing health inequities for many groups, particularly those underserved by the existing system. This is often due to overlapping social, clinical, or occupational risks.
26. Age-standardised rates of hospitalisation for COVID-19 are higher in Māori and Pacific Peoples than the general population, with a recent increase in rates of admission for Māori increasing to rates of 0.9 per 100,000. The cumulative total for the year shows Pacific Peoples being 2.3x and Māori 1.8 times the risk of hospitalisation than European or Other.

27. The most deprived populations continue to have the highest rates of hospitalisation and have close to twice the risk of hospitalisation compared with those who are least deprived (0.7 per 100,000 opposed to 0.4 per 100,000).
28. Disabled people who receive the Disability Support Services Payment also have an increased COVID-19 hospitalisation risk and are 4.2 times more likely to be admitted to hospital 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.<sup>5</sup>

*The mask burden is not spread evenly*

29. Conversely a small group are disproportionately impacted by the current mask mandate. The deaf community, individuals with dementia and people in full time healthcare all can have difficulties in mandated mask settings. Furthermore, these groups have more frequent engagement with the health and disability system.

### **New Zealand Bill of Rights Act 1990**

30. A requirement to wear a mask does not in principle engage the right to freedom of expression, and for those exceptional cases where the right may be engaged, the requirement to wear a mask is likely to be justified as a response to the increase level of COVID-19 in the community.



Signature  
Dr Nicholas Jones  
**Director of Public Health**

Date: 14 March 2023

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<sup>5</sup> <https://www.health.govt.nz/publication/covid-19-risk-among-disabled-people>

## Appendix 1: Healthcare settings where visitors must wear face masks

<p>Visitors at health care settings</p>	<p>Healthcare settings where visitors must wear masks:</p> <ul style="list-style-type: none"> <li>• primary and community care (eg, general practice)</li> <li>• iwi and Pacific healthcare providers</li> <li>• pharmacies – other than those located within supermarkets</li> <li>• hospitals</li> <li>• urgent care services (eg, after-hours clinics and accident and emergency)</li> <li>• disability support services</li> <li>• residential care (aged and disability-related)</li> <li>• diagnostic services (eg, blood testing, radiology services eg. MRI or X-rays)</li> <li>• dental therapy/oral health services.</li> </ul> <p>Other allied health services may include but are not limited to:</p> <ul style="list-style-type: none"> <li>• dietetics; occupational therapy; optometry; osteopathy; paramedicine; physiotherapy; podiatry; acupuncture; audiology services; chiropractic treatment.</li> </ul> <p>The mask requirements outline above do not apply to:</p> <ul style="list-style-type: none"> <li>• visiting psychotherapy, counselling, or mental health and addiction service premises</li> <li>• residents of residential care.</li> </ul> <p>Some health services may require all people on the premises wear a mask regardless of reason for being on site.</p>
<p>Patients/ consumers and clients in health care settings</p>	<p>Patients/consumers and clients are the same in this context – anyone getting treatment or health advice in a healthcare setting</p> <p>Most health services will request that patients wear a mask while on their premises. Requirements for patients are set by each facility, based on national infection prevention and control guidance.</p> <p>Typically face masks will not be required if the patient is an inpatient, in residential care, or is under the age of 12.</p> <p>If patients are not required to wear a mask under a healthcare facility's policy, it is still a good idea to wear one when entering to help protect yourself and others.</p> <p>Patients with mask exemptions should follow the local facility policy.</p>
<p>Workers in healthcare settings</p>	<p>Generally healthcare workers are recommended to wear a medical mask as a minimum when working in a patient or public-facing role and/or in a clinical or a public facing area.</p> <p>This includes both clinical and non-clinical support workers if they are working in a clinical zone or public facing area of a healthcare facility.</p> <p>Healthcare providers can make their own requirements for healthcare workers, patients and visitors.</p>

## Appendix 2: Use of face masks in the community

### New Zealand guidance (excerpts from Manatū Hauora and Unite Against COVID-19 website)

<p>Places and situations where masks are strongly recommended</p>	<p>There are places and situations where wearing a mask is strongly recommended. These include situations where there is a higher risk of you getting or spreading COVID-19 or another illness, such as if you are</p> <ul style="list-style-type: none"> <li>• <i>household contact</i> and are testing daily for five days. Wherever possible, it is strongly recommended that you wear a mask whenever you leave your home during the five days you are testing, even if the test result is negative. This is because if you are infectious, wearing a mask will reduce the risk of infecting other people that you meet. This is particularly important if you are using public transport, or if you are in a crowded indoor space. It is advisable that you do not visit vulnerable people (like elderly or immunocompromised).</li> <li>• <i>are at higher risk of getting very sick</i>. Wearing any type of mask will reduce your risk of becoming infected with an illness, but when worn correctly P2/N95 particulate respirator masks will offer you better protection over a medical or cloth mask.</li> <li>• <i>are travelling on public transport</i> – buses, commuter trains, on ferries and flights.</li> <li>• want to reduce your risk of becoming unwell, or</li> <li>• in a location where there is greater risk of infection spreading between people, such as closed spaces with poor ventilation; crowded places with many people nearby; close-contact settings, eg. where people have close face to face conversations.</li> </ul>
<p>Mask use at other locations</p>	<p>Some workplaces, organised special events, or maraes may ask people to wear a mask as a condition of entry. This will be at their discretion and no longer a government requirement. It is important to respect those who continue to keep wearing masks for the protection they offer against COVID-19.</p>

## Appendix 3: Letters to the Director-General of Health requesting mask mandates be removed from ARC settings



### CARE ASSOCIATION NEW ZEALAND

1/3 Price Crescent,  
Mt Wellington Auckland 1060  
09jelica@gmail.com

10<sup>th</sup> March 2023

Dr Diane Sarfati  
Director General of Health  
Chief Executive of Ministry of Health Manatū Hauora

Via email; [Harriette.Carr@health.govt.nz](mailto:Harriette.Carr@health.govt.nz)

Tēnā koe Dr Sarfati,

#### **Re: Change to public health order for visitor mask wearing in aged residential care settings**

The Care Association New Zealand (CANZ) and New Zealand Aged Care Association (NZACA), and the NZACA Nursing Leadership Group are writing to request a change to the public health order for visitors to mask in aged residential care settings.

We ask that at the upcoming Public Health Risk Assessment meeting, consideration is given to allowing each aged care facility to undertake its own risk assessment for the management of Covid and other respiratory illnesses.

#### **Reasons for change**

The aged residential care sector has responded positively over the pandemic response to manage infection prevention and control and is in a knowledgeable and skilled position to “flex up and back” as Covid and respiratory infections increase and decrease.

Over the past three years, the sector has increased surveillance and monitoring (internally and externally), implemented robust staff and visitor education, enacted vigilant infection control practices and strengthened its understanding of the impact of respiratory illness on the elderly.

There are considerable infection prevention and control resources that exist within the community and Te Whatu Ora to contact for additional guidance and support.

We would welcome the ability to manage the risk of Covid and other respiratory illnesses independently, with the knowledge, skills and resources that exist within the aged care and wider health sector.

Ngā mihi nu



Jessica Buddendijk  
CANZ executive





10 March 2023

Dr Diana Sarfati  
Director-General of Health  
Chief Executive of the Ministry of Health Manatū Hauora

Via email [diana.sarfati@health.govt.nz](mailto:diana.sarfati@health.govt.nz)

Tēnā koe Dr Sarfati,

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**Reasons for change**

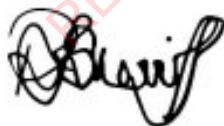
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We would welcome the ability to manage the risk of Covid and other respiratory illnesses independently, with the knowledge, skills and resources that exist within the aged care and wider health sector.

Ngā mihi nui



Rhonda Sherriff  
NZACA Clinical Advisor  
Member of the NZACA Nursing Leadership Group



# Memo

## COVID-19 Public Health Risk Assessment – 16 March 2023

<b>Date:</b>	22 March 2023
<b>To:</b>	Dr Diana Sarfati, Director-General of Health   Te Tumu Whakarae mō te Hauora
<b>Copy to:</b>	Dr Andrew Old, Deputy Director-General, Public Health Agency   Te Pou Hauora Tūmatanui, Manatū Hauora   Ministry of Health
<b>From:</b>	Dr Nicholas Jones, Director of Public Health, Public Health Agency Te Pou Hauora Tūmatanui Manatū Hauora Ministry of Health
<b>For your:</b>	Information and Decision

### Purpose of report

1. This memo provides advice from the Director of Public Health following the 16 March 2023 COVID-19 Public Health Risk Assessment (PHRA). That PHRA considered whether any changes are required to existing COVID-19 settings, including mandatory requirements and other matters based on the current outbreak context and modelling.

### Summary of Recommendations

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

#### 1. Face masks

<b>Current requirement</b>	The COVID-19 Public Health Response (Masks) Order 2022 specifies that: <ol style="list-style-type: none"> <li>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</li> <li>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).</li> </ol>
<b>Director of Public Health recommendation</b>	<b>Revoke</b> the current face mask mandate in health service settings, once Te Whatu Ora and Manatū Hauora implement national infection prevention and control (IPC) guidance, before the Order is revoked, to support stakeholders to manage risk levels on their premises
<b>Rationale for the decision and any additional comments</b>	To move away from broad health sector wide emergency measures will move some of the responsibility back to health care providers. This enables providers to create bespoke policies to best cater to their respective

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

<b>Current requirement</b>	Mandatory 7-day self-isolation of COVID-19 cases.
<b>Director of Public Health recommendation</b>	<b>Retain</b> the 7-day case isolation requirement.
<b>Rationale for the decision and any additional comments</b>	<p>Case isolation is one of the cornerstone measures of New Zealand's public health response to COVID-19. This measure significantly limits transmission of COVID-19 by reducing the proportion of infectious people having contact with and infecting others in the community, including vulnerable populations. Without government mandated case isolation, it is highly likely that adherence to guidance would be lower, resulting in an overall increase in transmission and case rates. Retaining case isolation will support ongoing mitigation of disproportionate impacts on vulnerable populations, provide lead-in time for the bivalent rollout to take effect and to manage potential pressures impacting on the health system as we head into winter.</p> <p><i>There was broad support among Committee members for retaining the 7-day case isolation requirement.</i></p>

## 3. Point of Care Test Order

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

<b>Rationale for the decision and any additional comments</b>	<p>To increase the proportionality of COVID-19 measures because:</p> <ol style="list-style-type: none"> <li>1. false positive and negative test results no longer pose a significant risk as the COVID-19 management strategy has changed, the public is not required to use Government funded tests, and the market is already saturated with approved tests, and</li> <li>2. the quality control of COVID-19 testing products can be carried out via a procurement process, and through other existing regulatory mechanisms such as the Consumer Guarantees Act 1993</li> </ol> <p><i>The Director of Public Health outlined the recommended change to the Point of Care Test Order and the rationale for the change. The committee was not asked to provide further comment, noting that a separate consultation process with the COVID testing team has already provided advice.</i></p>
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## Background

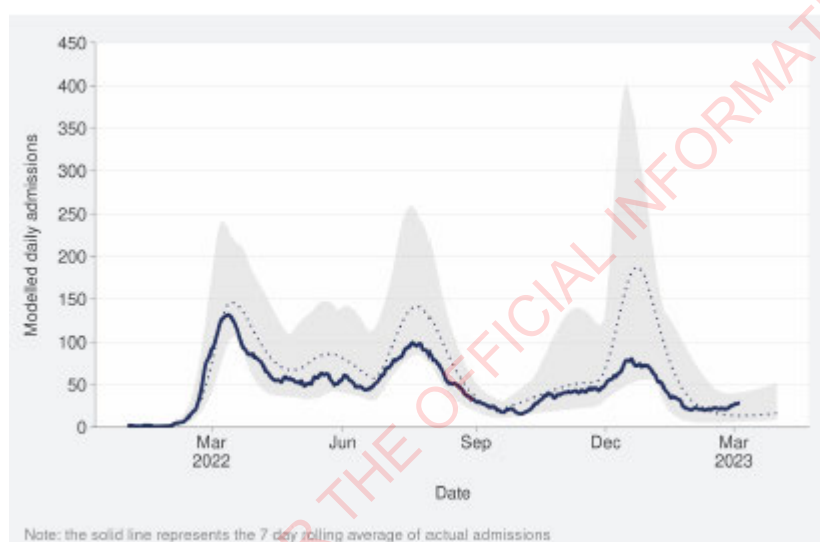
3. The COVID-19 Public Health Response Act 2020 requires that the Government keeps Orders under regular review to ensure that any limitation they impose on rights or freedoms under the New Zealand Bill of Rights Act 1990 is justified and proportionate to the risk posed by COVID-19.
4. The purpose of the COVID-19 PHRA is to assess the current and medium-term COVID-19 risk and to consider whether there needs to be any change to the suite of public health measures to manage the risk. This can include recommendations to relax or escalate risk mitigation measures. In addition, the PHRA fulfils the legal requirement to keep mandatory measures (made via Orders) under regular review to ensure that they remain necessary and proportionate.
5. When combined, individual measures form a pragmatic approach to managing COVID-19. There are interdependencies between each, and we must remain aware of how they form a coherent package for the public to encourage and support public health behaviours necessary to reduce transmission and limit the impact of COVID-19.
6. The Government's response is based on a mix of mandatory and non-mandatory measures, focused on increasing immunity through access to vaccination and antivirals; incentives for people to stay home when they have COVID-19; and ensuring the ongoing protection of priority and at-risk populations. This includes proactive service delivery and targeted communications to increase the level of reach and uptake of measures amongst these communities.
7. The principle of proportionality is a key consideration. This principle requires that the least restrictive measures are used and for no longer than is necessary to achieve the objective of preventing, minimising, or managing the COVID-19 public health risk. When assessing proportionality, it is important to account for the objectives of both Te Tiriti o Waitangi and equity considerations as less proportionate, more restrictive measures may be required to achieve these objectives.

## Summary of outbreak status and epidemiological context

*COVID-19 case rates have stabilised but hospitalisations have increased*

8. Overall, the key measures of infection (levels of viral RNA in wastewater and reported case rates) used to monitor the COVID-19 epidemic remain stable compared to the last PHRA in January 2023 in most regions after increasing slightly in late February 2023.
9. COVID-19 related hospital admission rates have increased in the week ending 5 March 2023, following the recent slow increase in cases in late February, and are tracking in the upper bound of the 95% confidence interval (figure 1). Hospitalisations that are classified as being 'for COVID-19' are higher than the incidental rate. Since October 2022, COVID-19 related hospital admissions of patients admitted for COVID-19 related illness were 1.8 times higher rather than those admitted who incidentally had COVID-19.

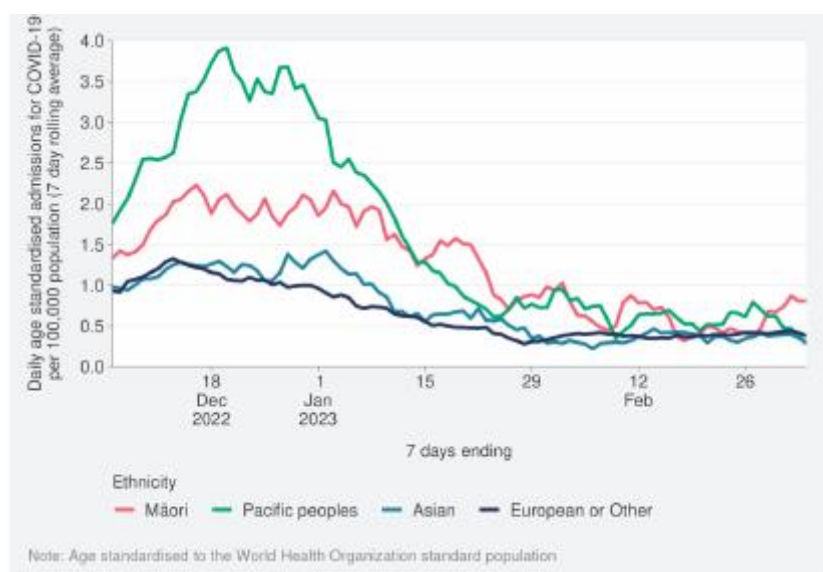
Figure 1 - COVID-19 Modelling Aotearoa hospitalisation scenarios compared with national through 12 March 2023<sup>1</sup>



*Vulnerable populations have the highest rates of hospitalisation*

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

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



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

*There is a slower but steady uptake of the second booster*

12. The first booster has seen a steady uptake with 71.5% of the eligible population having received their first booster. The second booster has seen a slower but steady rise in uptake with 49% of the eligible population receiving this dose. This is specifically of note as the second booster is only available to higher risk populations.

*There is currently no dominant variant in the community but the proportion of XBB cases is growing quickly*

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

## Risk assessment

*Cases rates have stabilised*

14. Since the last PHRA, case rates rose slightly over late February and stabilised over the week ending 12 March. Modelling undertaken in late 2022 suggests that, assuming no substantial policy or other changes, this will continue into April, but the modelling is uncertain because it does not factor in some context and influences, such as the possibility of new variants of concern, changes to vaccine eligibility or the use of antivirals.

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

*Variants of concern*

16. The proportion of Omicron sub-variant XBB.1.5 cases in the community has grown to 22% in cases that are whole genome sequenced. While U.S. data suggests that it has a growth advantage over other sub-variants, the immunity profile of the New Zealand population is different to that of the U.S. population so it is unclear how this sub-variant will affect New Zealanders.

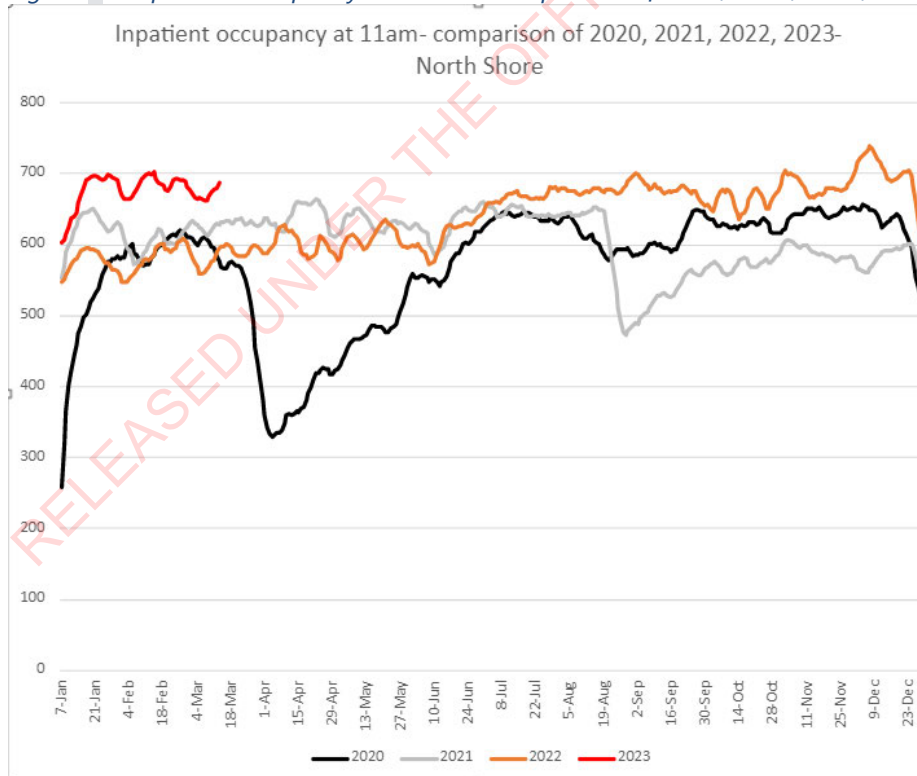
*Uptake of therapeutics*

17. Uptake of COVID-19 therapeutics has been steadily increasing over recent months, and uptake is high among vulnerable populations. Approximately half of Māori and Pacific Peoples aged 50-64 years who report positive tests were accessing antivirals in the week ending 5 March. It is also important to note that uptake of therapeutics cannot be disaggregated by disability status, so it is uncertain what the uptake of therapeutics is among this group.

*The health sector is under pressure*

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

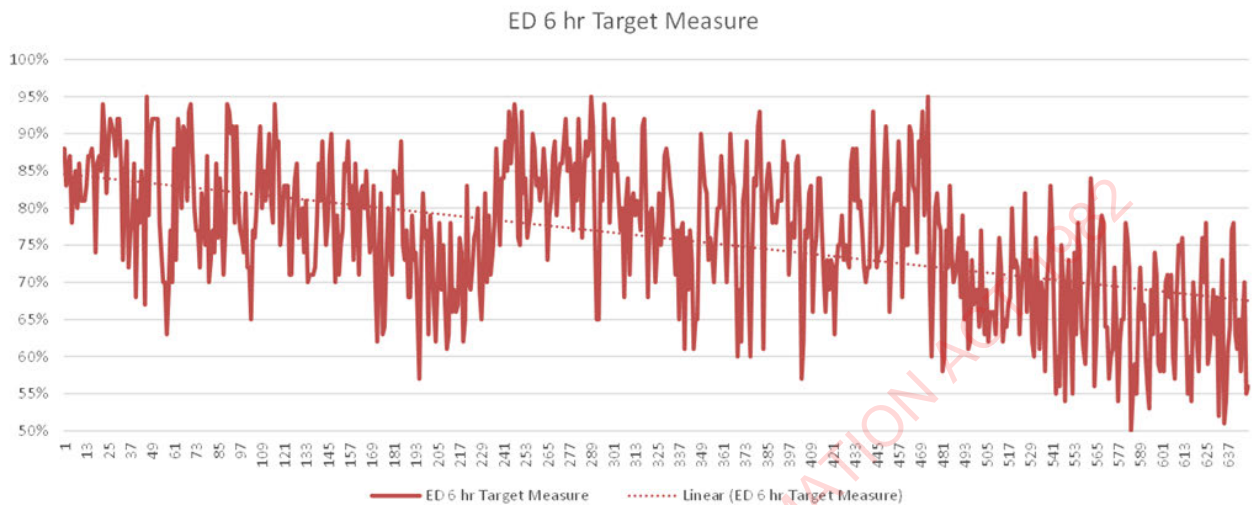
Figure 3 – Inpatient occupancy at 11am – comparison of 2020, 2021, 2022, 2023 – North Shore Hospital



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

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

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



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

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

- 21. In taking the above trends into account the Director of Public Health’s assessment of current public health risk due to COVID-19 is that the risk to the population overall remains low but is increasing. The risks to more vulnerable members of the population remain higher than for the general population but may be reducing with the commencement of bivalent vaccine and extensive use of antivirals.

**The basis for recommendations on current measures within this context**

- 22. As Aotearoa New Zealand approaches the winter illness season it is critical that the public health response remains effective in limiting the spread and impacts of COVID-19 infections. As noted in paragraphs 17-18, the health system is already under much higher pressure than is typical at this time of year compared to other years during the pandemic. Increases in the spread of COVID-19 worsens this pressure and restricts the ability of the health sector to deliver services to both COVID-19 and non-COVID-19 patients.
- 23. It is also important that vulnerable groups are well protected, particularly until the Government rolls out the bivalent booster dose to vulnerable populations and can monitor its uptake. Ensuring that vulnerable populations can receive the booster before self-isolation requirements are lifted, protects both the wellbeing of those vulnerable to COVID-19 and health system capacity.

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

- 24. [Redacted]



25. [REDACTED] s 9(2)(h) [REDACTED]  
[REDACTED]  
[REDACTED] and [REDACTED]  
[REDACTED]
26. Separate advice is currently being prepared in consultation with Crown Law on a further authorisation from the Prime Minister.

*Comment on key non-mandatory measures*

27. With daily case numbers staying relatively constant over recent weeks, rising hospitalisations and high pressure on health sector capacity, the risk posed by the virus to many groups within the population remains significant.
28. Uptake of the first booster is stable at 71.5%, and uptake of the second booster uptake has risen slightly to 49% of the eligible population. The bivalent booster has become available to eligible members of priority groups from 1 March 2023, and it becomes available to those aged 30 years and over on April 1. The bivalent booster provides targeted protection against Omicron subvariants, which is important for protecting vulnerable people and health sector capacity as Aotearoa New Zealand moves toward the winter illness season with an Omicron 'variant soup'.

**Summary of Committee deliberations of case isolation requirements**

29. Case isolation remains the most effective measure to reduce the onward transmission of COVID-19. The requirement to isolate as a case is a significant imposition on a person's right to freedom of movement. Recent World Health Organisation (WHO) patient management guidelines have also noted that risks of transmission from asymptomatic cases are considerably lower than from those with symptoms.
30. The degree to which retention of an order requiring isolation contributes to the actual isolation behaviour of cases may be changing over time. Limited data from a behavioural insights survey in February suggests that actual isolation following testing positive is decreasing (67%) but numbers included in the survey were small. It is noted that there is no legal requirement to either test or report results of tests although the ongoing provision of leave support and antivirals may be incentivising both testing and reporting. It should be noted that modelling results (provided in appendix 1) do not explicitly incorporate any changes in behaviour but rather provides a range of scenarios that could occur as a result of isolation behaviour change.
31. Despite these limitations in the evidence base, the Committee was reluctant to remove or reduce the current 7-day case isolation requirement. As detailed in Appendix One, other factors factoring into these deliberations are:
- Modelled increases in transmission following the removal of the mandate.
  - International and domestic experience showing reduced adherence, but inconclusive results regarding infection rates if the mandate is removed.
  - Limited benefits in the reduction of the isolation period for asymptomatic cases.
  - The potentially disproportionate impact on vulnerable populations.

*Considerations if the requirement to isolate is not maintained*

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

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

33. If this occurs, there is a need to ensure that there is a smooth transition to a new approach. There are also a set of actions that could be undertaken to mitigate the effects of removing the mandate. If the isolation mandate is removed, I would recommend the following measures:
- a. Clear guidance that cases should isolate for 7 days.
  - b. Maintain guidance and functionality to report COVID-19 test results – this information (even if not capturing all cases), still provides important information on case trends to assist health service planning and is also the main mechanism for identifying people requiring support and/or likely to be eligible for antivirals.
  - c. Establish a mechanism to ensure cases are aware of the recommended isolation period including advice that they may be directed to isolate by a Medical Officer of Health should a failure to isolate place vulnerable persons at risk
  - d. Continue the Leave Support Scheme (LSS) – potentially in a more targeted form as has been used in other jurisdictions. This would support people who might otherwise find it difficult to isolate to do so.
  - e. Strengthen effective public health measures that do not involve limitations on individual rights – for example, systemic improvements to ventilation in high-risk settings.
  - f. Consider whether eligibility for antivirals should be further expanded.
34. In addition, I note that we have received feedback previously from other agencies regarding their concerns if isolation were to be removed:
- a. Some population groups are more at risk of severe outcomes than others, and that removing mandatory isolation may have impacts for these groups in terms of their ability to take part in daily activity and social interactions. This is particularly likely to be the case where there are not other safeguards in place – such as those outlined in para 33 above
  - b. If a change was to occur, 6 weeks would be required to make the necessary operational changes, such as updating providers on new advice, and reviewing collateral.

### **Summary of Committee deliberations of mask requirements**

35. Masks are still considered an effective measure, particularly in protecting vulnerable populations. While data is limited, there is anecdotal evidence to suggest a degree of non-compliance in certain settings and fatigue within certain facilities. Furthermore, there are increasing calls for organisations to be able to develop their own policies to both manage the risk and respond to the needs of staff and patients specific to their context.
36. While there was limited support among Committee members for removing face mask requirements on public health grounds, some members expressed that the requirement that visitors wear masks is no longer proportionate. This is because compliance with the requirement is waning, and health providers can assess the risk levels unique to their premises and of enforcing their own policies on who should be wearing masks.

37. For example, enforcement of face mask requirements in non-hospital health settings such as pharmacies is challenging as it is not always clear to pharmacy workers and customers who is considered a visitor who must wear a mask, and who is a patient (not required to wear a mask). The intended interpretation is that everyone who enters a pharmacy is required to wear a mask, but this requirement is rarely observed and is difficult to monitor and enforce.
38. Committee members from Te Aka Whai Ora did not support the removal of mandatory face mask requirements, due to the potential for adverse impacts this would have on Māori who already suffer disproportionate health outcomes. Committee members noted the lack of evidence specific to the likely impacts on Māori. Similarly, Whaikaha members did not support removal of the visitor mask mandate noting that even with the current mandatory settings in place, DSS recipients who receive residential support are 19% more likely to report a positive COVID-19 test result, 8 times more likely to be hospitalised and 47 times more likely to die with or of COVID-19. Any change in in these data that might arise from adopting a policy-based approach to visitor mask use has not however been quantified.
39. Whaikaha recommends that decisions to remove mandatory face mask requirements are not made until such a time that regular data is collected on DSS recipients' COVID-19 outcomes.
40. While there was limited support from Committee members to remove mandatory face mask requirements, there was broad support for extensive consultation of affected groups, and for implementing national IPC face mask guidance prior to removing the mandatory requirements, if the Minister decides to revoke the Order. Additionally, some members suggested that the Minister consider other alternatives besides only a switch to national IPC mask guidance.
41. It is important to note, however, that not all sectors or persons conducting affected businesses or undertakings will have the capacity or capability to do this themselves. Te Whatu Ora emphasises that when schools were asked to undertake their own risk assessments in line with guidance, it placed on them a significant additional burden and in many instances resulted in schools opting for no mask requirements to avoid this burden and conflict with their communities. This highlights the need for national IPC mask guidance to be comprehensive and effectively communicated if mask requirements are removed. There is currently IPC guidance for healthcare staff and patients provided by Te Whatu Ora however this does not extend to visitors to these facilities. Before removing the Mask Order, Te Whatu Ora and Manatū Hauora will need to provide clear and considered guidance on appropriate mask wearing procedures for each healthcare setting.

*Director of Public Health comment on mask requirements*

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

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

### **Removing the point of care test Order**

42. The point of care test Order (POCT Order) is a regulation that restricts the importation and supply of a POCT (including RATs) unless provided an exemption from the Director General of Health.
43. The POCT Order was originally enacted during the “Elimination” strategy where a single positive test could lead to rights-limiting requirements such as self-isolation or a lockdown, and therefore the risk of a false negative or positive result was of high concern.
44. The retention of the POCT Order is no longer considered appropriate because:
  - a. false positive and negative test results no longer pose a significant risk as the COVID-19 management strategy has changed, the public is not required to use Government funded tests, and the market is already saturated with approved tests and
  - b. the quality control of COVID-19 testing products can be carried out via a procurement process, rather than a separate regulation such as the Order, and through other existing regulatory mechanisms such as the Consumer Guarantees Act 1993.
45. See Appendix 3 for further information on the removal of the POCT Order.

### **Equity and Te Tiriti o Waitangi considerations for maintaining measures**

#### *Impact of COVID-19 on vulnerable populations*

46. Pacific peoples and Māori continue to have the highest hospitalisation rate compared to other ethnicities, after standardising by age. Māori are 1.8 times more likely to be admitted to hospital with COVID-19 than European or Other, and Pacific Peoples are 2.3 times more likely. Age standardised rates of Pacific Peoples being admitted to hospital with COVID-19 have decreased since the last PHRA and have remained stable over the last fortnight
47. COVID-19 attributed mortality rates are also higher among Pasifika (2x higher) and Māori (1.7x higher), compared to European or Other ethnicities.
48. The most deprived populations continue to have the highest rates of hospitalisation (0.7 per 100,000), almost double that of those who are least deprived (0.4 per 100,000). There is also an increased risk of COVID-19 attributed mortality for those in socio-economically deprived groups. The most deprived populations have 2 times the risk of mortality when compared with those in the least deprived population.
49. Disabled people aged <65 years who receive Disability Support Services have a hospitalisation risk that is 4 times higher than the rest of the population. Further, rates of COVID-19 attributed mortality are 15 times higher among this group compared to the rest of the population.
50. Many disabled people attend health care appointments and pharmacies for their medication and have expressed their preference that mask mandates are retained in health care settings, in particular pharmacy and primary care.
51. Despite the lack of information on whether any changes would increase the disproportionate impact on these populations, Committee members emphasised that any reductions of public health measures will increase prevalence of Long COVID, and that this increased prevalence will disproportionately impact Māori, Pacific Peoples and disabled people due to their vulnerability to infection. This is particularly concerning given that the

criteria for diagnosing Long COVID and Long COVID support systems remain under development and given that these groups are more often under-diagnosed and under-treated when accessing healthcare.<sup>3 4 5 6 7 8</sup>

### *Addressing equity concerns*

52. There is an ongoing and strong concern among Committee members that a reduction in measures would put vulnerable populations at disproportionate risk. They emphasise that decisions to step down measures should not be made based on population-wide data and context, but rather on the data representing specific vulnerable groups such as disabled people, Māori and Pacific people, and older people.
53. Retaining 7-day self-isolation for cases limits the spread of COVID-19, and this allows time for the roll out and uptake of bivalent booster doses, increased access to therapeutics, and improvement of the diagnosis and treatment of long COVID to protect those who are most vulnerable to the impacts of infection.
54. § 9(2)(f)(iv)  
§ 9(2)(f)(iv) COVID-19 vaccination efforts and Māori COVID-19 communications have highlighted the importance of Māori leadership at all levels; putting equity at the centre of decision making; enabling providers to build relationships with communities; enabling communities to lead responses, and collaboration across agencies. It also notes the disproportionate risk that Māori face of getting long COVID, and highlights how certain options would minimise this risk.
55. The increasing accessibility and uptake of antivirals for vulnerable populations is providing greater protection against the impact of infection. In the age bracket 50–64 years, antivirals have been provided to 51% of Māori cases and 50% of Pacific Peoples cases.
56. The Director of Public Health notes that the costs of measures may also be being borne disproportionately by disadvantaged groups who despite being eligible for leave support may have less secure employment and therefore be reluctant to take leave. Parents of test positive children may also be less likely to take parental leave to care for isolating children and isolating children from disadvantaged groups may be more vulnerable to educational disruption.

### *Equity considerations in these recommendations*

57. It is important that public health measures improve health equity and uphold Te Tiriti o Waitangi principles by protecting groups who are most vulnerable to COVID-19.
58. Committee members highlighted the role that self-isolation plays in protecting vulnerable communities in Aotearoa New Zealand.
59. Shifting mandatory case isolation to guidance is likely to disproportionately affect those who do not have the ability to choose to follow the guidance. This includes people in precarious employment, those unable to work from home, workers with limited sick leave and other vulnerable populations, particularly those with other socioeconomic disadvantages.
60. Committee members emphasised that any stepping down or removal of protective measures should be accompanied by specific alternative settings, modelling against those alternative settings, and extensive engagement with stakeholders from vulnerable groups prior to stepping down measures.

61. Subsequently, the recommendation to revoke the mask order is accompanied by a Manatū Hauora and Te Whatu Ora plan to develop IPC guidance to empower stakeholders in the health and disability sector to manage the risk levels relevant to their premises and roles, and a timeframe which allows them time to operationalise this guidance before a decision is made to revoke the mask order.
62. Stakeholders from the disability community have expressed concern that there is insufficient data on the impact that removing protective measures would have on disabled people. They argue that decision makers should consciously factor in this absence of evidence before making decisions that could profoundly impact disabled people.
63. If the COVID-19 situation significantly changes, then enforceable or mandatory measures may be re-introduced to protect our vulnerable populations. This would be an effective and proportionate response to a worsening risk profile.

## **New Zealand Bill of Rights Act 1990 (NZBORA) – Crown Law advice (legally privileged)**

### *Case Isolation*

64. s 9(2)(h)

65.

66.

67.

s 9(2)(h)

68.

69.

70.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

### Next steps

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

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

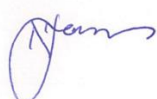
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## Recommendations

It is recommended that you:

1.	Note	that key indicators currently suggest overall COVID-19 public health risk is low	Noted
2.	Note	that at-risk groups remain at disproportionately high risk	Noted
3.	Agree	to recommend that the Minister of Health remove current face mask requirements	Yes/No
4.	Agree	to recommend that the Minister of Health retains current case isolation requirements	Yes/No
5.	Agree	to recommend that the Minister of Health remove point of care test Order requirements	Yes/No
6.	Note	that the section 8(c) Prime Minister Authorisation Notice advice will be provided to the Prime Minister in parallel with the advice on these public health measures, and the Prime Minister's decision on that advice may limit the measures that can be used	Noted
7.	Note	that Manatū Hauora is working with Te Whatu Ora on developing national IPC mask guidance to coincide with a removal of the current face mask requirements	Noted
8.	Note	that the lead time for development of a consistent national infection prevention and control guidance/any subsequent workforce development is six weeks	Noted



Signature

Dr Nicholas Jones

**Director of Public Health**

**Public Health Agency | Te Pou Hauora Tūmatanui**

**Manatū Hauora | Ministry of Health**

Date: 22 March 2023



Signature

Dr Diana Sarfati

**Director-General of Health | Te Tumu Whakarae mō te Hauora**

**Manatū Hauora | Ministry of Health**

Date: 23 Mar 2023

## Appendix One – Case Isolation

### The potential impact of removing case isolation

73. Modelling suggests that removing mandatory requirements and switching to guidance on measures relating to household contact isolation and mask wearing on 12 September 2022 did impact transmission. Modelling indicates that transmission increased by approximately 20% from mid-September to early November, likely due in part to the changes in behaviour resulting from the removal of mandatory measures. The expected increase in transmission prior to this switch to guidance was 8.5%, based on international evidence about levels of compliance under guidance. This is likely to have been due to the use of a more conservative assumption regarding community adherence than is likely to have been the case.
74. Provisional modelling results provided by COVID-19 Modelling Aotearoa indicate that:
- changes to case isolation requirements (and other behaviour changes or measures) that result in a moderate increase in transmission of 10%, will cause an approximate 54% increase in peak bed occupancy in hospitals at some point in the 26 weeks following the change
  - changes in case isolation requirements (and other behaviour changes or measures) that result in a higher increase in transmission of 15% will cause an approximate 88% increase in peak bed occupancy in hospitals over the 26 weeks following the change.

**Table 1. Model results for the short-term and long-term impact of ending mandatory COVID-19 isolation requirements.** Differences in cumulative infections, COVID-19 hospital admissions, and COVID-19 deaths, in the 7 weeks and 26 weeks following the policy change, and peak hospital occupancy during the 26 weeks following the policy change, under three model scenarios (+5%, +10% and +15% change in transmission on 21 March 2022). All results are relative to the baseline model with no policy change. In each table cell, the first line shows change in absolute numbers and the second line shows relative (percentage) change compared to baseline. Values in brackets represent the 95% confidence intervals on these differences.

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

75. When interpreting these results, it is important to be aware of the following interpretation caveats:
- It is not possible to determine the size of the effect that removing mandatory isolation would have on cases.
  - Modelling does provide a useful range of potential impacts under different scenarios. However, it is not a prediction, and results are reliant both on the model itself and the assumptions it uses.

- c. The model assumes that there is no major new variant.
- d. The model does not take into account use of anti-viral therapies and the impact that they may have on hospitalisations and deaths.
- e. The baseline modelling scenario (that assumes no changes to isolation, and does not account for behaviour change over winter, or other changes) represents a long-term projection associated with approximately half as many deaths as occurred in the winter 2022 wave (1,929 attributable deaths occurred during the equivalent 26-week period in 2022, compared to 891 in the baseline modelling scenario). However, a winter model would likely predict a higher case load than the current baseline model, but not as high as the 2022 winter.
- f. Modelling does not account for hospitalisations and deaths for other conditions and health events for which there are heightened risks following COVID-19 infection (for example, cardiovascular events<sup>9</sup>). It also does not include the impact of delayed care and/or workforce pressures on these metrics.

*Are people who test positive isolating?*

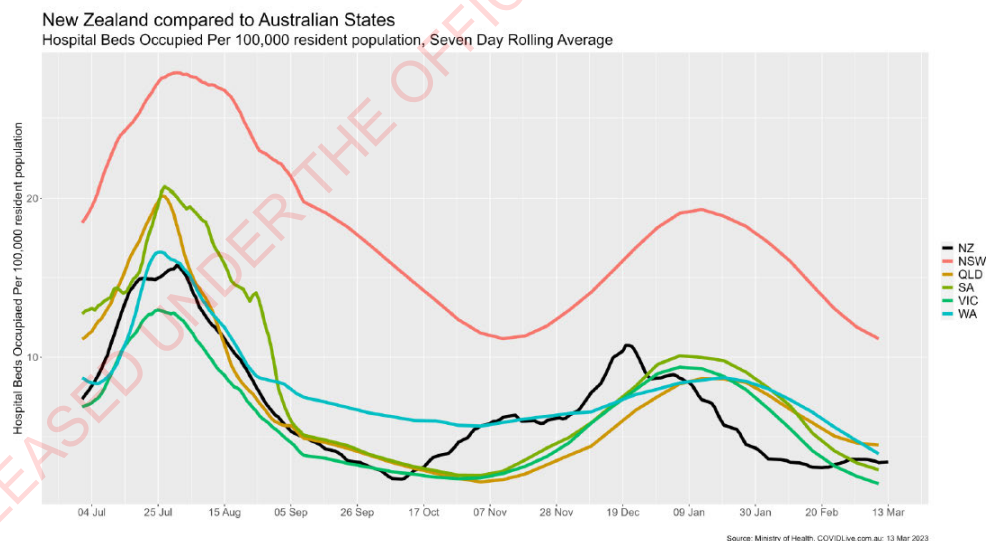
- 76. A survey series commissioned by Manatū Hauora from September 2022 to February 2023 provides insight on current attitudes and actions in relation to the requirement for cases to isolate:
  - a. intention to self-isolate has remained high throughout this period – the percentage of participants reporting that they would be ‘likely’ or ‘very likely’ to isolate if they were a case was 83%, 85% and 85% in September 2022, November 2022, and February 2023 respectively;
  - b. the proportion of people who test positive who also report isolating has dropped slightly (67% in the February 2023 survey compared to 78% in the November 2022 survey).
- 77. The Institute of Environmental Science and Research (ESR) has produced an exploratory estimate of the case ascertainment rate (CAR), based on comparing reported cases and wastewater results. However, as noted previously, CAR is an exploratory metric. Since this metric was first reported in late 2022, results have been more variable than expected. As a result, this metric is not currently considered sufficiently reliable.

*What can we learn from the experience in other jurisdictions?*

- 78. Evidence from overseas from early 2022 suggests that a legal requirement to isolate is likely to have significantly greater **adherence** than a recommendation to isolate. For example, in the United Kingdom, there was a significant drop in adherence after the legal requirement was dropped on 24 February 2022. Survey data of people who tested positive for COVID-19 showed 80% were fully compliant in February but dropped to 64% in early March and then 53% in late March 2022.<sup>10</sup>
- 79. It is difficult to compare the impact that the removal of isolation mandates in other jurisdictions has on **infection levels**, as many countries also changed metrics relating to the level and/or severity of infection at the same time. In addition, changes to testing practices both in hospital and of people who have died (which may or may not have occurred at the same time as the removal of isolation) also have the potential to impact on hospitalisation and mortality data. For example, several states in Australia (VIC, NSW)

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

80. However, with that caveat, data on hospitalisations and deaths in Australia is likely to represent the most appropriate comparator for the New Zealand context. Australia and New Zealand both largely avoided significant levels of infection until Omicron, both had relatively well-vaccinated populations at that point, and the two countries have broadly similar population age structures. Hospitalisations and deaths are likely to be less affected by changes in reporting than case data.
81. Direct comparison of hospital bed occupancy for COVID-19 cases per capita in Australian states and New Zealand is provided in Figure 3 below. This comparison suggests the difference in isolation policy is not impacting on bed occupancy. However, caution must be taken in interpreting this data as the definition of what is recorded as a COVID-19 hospitalisation differs by jurisdiction:
- New Zealand – cases are recorded for the full duration of their inpatient stay (from when they test positive)
  - Victoria – only counts COVID-19 hospital admissions if they are currently in hospital and testing positive (typically 5-7 days)
  - Other Australian states – some other states more completely match recorded cases with admissions data, and report as COVID-19 patients for a full 14 days regardless of whether the person is still testing positive.<sup>11</sup>



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

### Case isolation is still considered to be an effective measure

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

- a. A legal requirement to self-isolate remains a highly effective tool in New Zealand's COVID-19 public health response. It significantly limits transmission of COVID-19 by breaking the chain of transmission by reducing the amount of infectious people having contact and infecting others within the community. In turn this limits hospitalisation, including the need for ICU care, and deaths, especially for more vulnerable populations. It also limits the number of people who will develop post-acute sequelae such as Long COVID.
- b. Without mandated case isolation, it is highly likely adherence to guidance would be lower, resulting in more infectious cases seeding community transmission and increasing overall case rates.
- c. Best practice approach to managing highly infectious notifiable diseases is for cases to isolate during their period of infectivity. This is the most effective tool for controlling disease transmission. The high transmissibility of COVID-19 reinforces the importance of case isolation.
- d. Other infection control tools, such as requiring face masks or physical distancing are significantly less effective than isolation. We have been able to recommend removing or reducing some of those other tools in part because case isolation has remained in place. However, there is no combination of other mechanisms that would come close to producing the broad public health benefits provided by mandatory case self-isolation, including the minimisation of disruption to essential services caused by high transmission of COVID-19.

*Changing the mandatory period of isolation has marginal benefits*

84. *While there* has been a reduction in isolation requirements over the course of the outbreak, we have reached what is probably the minimum threshold for self-isolation of symptomatic cases to remain an effective intervention. A mandatory requirement for 5-day isolation would be less effective, as many people who are symptomatic may still be infectious to some degree on release at day 5.<sup>13</sup>
85. It is less clear for cases that remain asymptomatic as it is not known at time of positive test whether they are at the end of their infectious period or near the beginning. The WHO has recommended reducing the case isolation period to 5 days for cases who remain asymptomatic throughout the course of their infection.
86. Based on available information, most people who are symptomatic who are isolating are too sick to be able to work or go to school.
  - a. Based on data from healthcare workers in Canterbury, approximately 40% of cases were not well enough to return to work after completing 7 days isolation (noting that the survey was carried out earlier in the pandemic, and with the current outbreak context consisting of multiple waves and boosters, the duration of illness among healthcare workers may have decreased since).
  - b. Analysis of publicly available data from the Household Labour Force Survey (HLFS) undertaken by Statistics New Zealand has shown that there is a clear increase in the rates of being absent or working less due to sickness across 2022, ramping up towards Q2, and maintaining across the year. This coincides with large scale spread of COVID-19 in the community. The change is very clear when compared to rates prior to 2022, which were fairly consistent, with some seasonal fluctuations. While no causal inferences can

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

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

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

88. It is likely that an increase in community cases would affect some communities and population groups more than others. Specifically:
- a. Older people – the strongest risk factor for COVID-19 mortality is age.
  - b. Māori and Pacific peoples – a Manatū Hauora report on inequities in COVID-19 mortality found that Māori and Pacific peoples had more than twice the risk of death compared to European and Other groups.<sup>14</sup>
  - c. People living in deprived areas – there is an acknowledged differential exposure to COVID-19 risk related to socioeconomic status. People in lower socioeconomic groups are more likely to work in jobs with greater risk of exposure, to live in larger and typically more crowded houses, and to have underlying risk factors. If there are more infectious people circulating in a community with more baseline contacts, this increases the likelihood of onward transmission. The Manatū Hauora report on inequities in COVID-19 mortality referred to above found that people from the most deprived communities were 3 times more likely to die from COVID-19 than those from the most affluent communities.<sup>15</sup> People who are socioeconomically deprived are more likely to face challenges in being able to isolate compared to people with greater access to socioeconomic benefits. This includes differing access to sick leave, income loss, and potential pressure from employers to return to work. Earlier return to work comes at the cost of increasing transmission, which is likely a more significant effect on health outcomes and ability to work due to illness. As a result, people who experience higher levels of socioeconomic deprivation may be more likely to not test, not report results, or break isolation, potentially causing further cases and further inequities.
  - d. Disabled people – a recent report on the burden of COVID-19 on the disabled population found that this population group had significantly higher risk of severe outcomes than the general population.<sup>16</sup> People receiving Disability Support Services (approximately 43,000 people), were 9% less likely to be COVID-19 positive, but 4.2 times more likely to be admitted to hospital for COVID-19, and 13 times as likely to die due to COVID-19.

- e. People with underlying health conditions – the Manatū Hauora report on inequities in COVID-19 mortality referred to above found that people with any comorbidities had more than 6 times the mortality risk of people without comorbidities.
89. See appendix 1 of the memo following 26 January 2023 PHRA meeting for more information on the rationale for continuing to require mandatory self-isolation for cases.

## Appendix Two - Masks

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

90. Evidence that wearing a face mask decreases the rate of COVID-19 community transmission (and other airborne respiratory viruses) is substantial (HR20221311 outlined the evidence base of their use and mandates). Further healthcare settings are an especially vulnerable setting, and it is paramount that the public are safe to access healthcare with minimal risk of catching COVID-19, and have the confidence to access the healthcare they require.

### *The Mask Order has adverse effects for some people*

91. The current Mask Order covers a broad range of environments such as health clinics, pharmacies, disability support services, and aged residential care homes, and masks are not always optimal for every setting. There is also a major difference in the length of time a person might be in a healthcare setting where the mask mandate is applied, ranging from a brief appointment to being full time resident.
92. This issue can arise for visitors to full-time residents in Aged Residential Care (ARC) facilities. For this group the health care setting is their home, and they often can have mobility issues which can make it difficult to leave the facility. The mask mandate means that all visitors to their home must wear face masks for the duration of the visit, unless an exception under section 6 of the Mask Order applies (such as they are eating or drinking, communicating with a person who is deaf or hard of hearing, or they have a physical or mental illness of condition or disability that makes wearing a mask unsuitable). There can be further complications depending on the health of the individual, such as residents with dementia finding masks disorientating, while for hard of hearing residents it is a barrier to communicate and can be very isolating.
93. While ARC stakeholders have indicated that they wish to enforce their own mask policies, comprehensive consultation of stakeholders from other affected healthcare settings on current mandatory mask requirements has not been completed.

### *The mandates are hard to enforce and compliance hard to measure*

94. The Mask Order specifically excludes staff and patients in healthcare settings. This, along with the broad collection of services covered under the healthcare mandate, creates confusion to the public about when and where masks are required.
95. For example, the Mask Order applies to visitors to pharmacies, who are not there for healthcare reasons (e.g., not picking up a prescription or buying a health care product). Differentiating a 'visitor' from a 'patient' in these facilities is difficult and makes mask messaging and enforcement particularly challenging. Furthermore, it is difficult to know whether the actual benefit of the mask mandate is being realised in these settings when the mandate does not apply to all customers at any given time.

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

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

97. Removing the Mask Order does not need to be a pivot away from using masks as a measure, but instead allows each facility to develop appropriate settings. Currently healthcare providers are already responsible for the health and safety measures of staff, patients and visitors in all other areas of health and safety. Replacing the Mask Order with guidance would allow healthcare providers to make mask policies consistent across the facility and ensure the measures taken remain proportionate to the risks.
98. It is important to note, however, that not all sectors or persons conducting affected businesses or undertakings will have the capacity or capability to do this themselves. Te Whatu Ora emphasises that when schools were asked to undertake their own risk assessments in line with guidance, it placed on them a significant additional burden and in many instances resulted in schools opting for no mask requirements to avoid this burden and conflict with their communities. This highlights the need for national IPC mask guidance to be comprehensive and effectively communicated if mask requirements are removed.
99. As discussed, the enforcement of the Mask Order is left to each facility and often not implemented. Allowing healthcare providers to create setting appropriate restrictions would increase the likelihood the facility would also enforce them.

*Appropriate IPC guidance will need to be prepared*

100. There is currently IPC guidance for healthcare staff and patients provided by Te Whatu Ora<sup>17</sup> however this does not extend visitors to these facilities. Before removing the Mask Order, Te Whatu Ora and/or Manatū Hauora will need to provide clear and considered guidance on appropriate mask wearing procedures for each healthcare setting, noting that there is currently no national IPC technical advisory group or equivalent group that is well-placed to develop this guidance.
101. More developed guidance and communications would also enable more broad public messaging about the value of masks for high-risk settings, particularly when community transmission risk escalates.

### **Appendix Three – Point of Care Test Order**

*The self-isolation requirement no longer requires the POCT Order*

102. The POCT Order has played a primary role in supporting the self-isolation requirement. It does this by ensuring the reliability of results produced by tests that legally require a COVID-19 case to self-isolate under the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022.
103. It is important that the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 is well supported because it imposes a significant limitation on a person's right



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

104. The POCT Order is no longer justified because it is no longer required to support the self-isolation requirement for COVID-19 cases. This is because:
  - a. there is currently a sufficient Government supply of approved RATs for the next 12 months
  - b. the public is not legally required to use Government funded tests
  - c. the private market is saturated with approved tests
105. Additionally, there are other mechanisms that ensure the quality of tests remain high.
106. Quality control of COVID-19 tests could continue through a procurement process instead of a separate regulation like the POCT Order (noting that there is currently no capability to proactively undertake this form of quality control).
107. New medical devices must be registered on Medsafe's Web-Assisted Notification of Devices (WAND) database within 30 days of being on the market. Medsafe can take post-market action to restrict sales of medical devices in Aotearoa New Zealand through WAND. While in vitro diagnostic devices such as COVID-19 RATs are currently exempt from this requirement, if the POCT Order is revoked this could be changed to provide further assurance that quality of tests sold in Aotearoa New Zealand remains high.
108. If the POCT Order is revoked and the options for increased quality assurance noted in paragraphs 10-11 are not implemented, then the quality of tests distributed and used in New Zealand remains assured under the Consumer Guarantees Act 1993, the Fair Trading Act 1986, and the Health and Disability Commissioner Act 1994.

#### *Implications for current Government-funded tests*

109. There are no risks with current products assessed and approved via the point of care exemptions process or with current Government supply of tests.
110. However, approved products require continued monitoring of expiry dates and efficacy of products to detect new variants as there is currently no process for post-market assessment or revisitation for in vitro products.
111. Revoking the POCT Order would mean that an internal validation process would be needed when purchasing new Government test supplies.

#### *Legal implications of retaining the POCT Order*

112. Other in vitro and COVID-19 testing products under the Medicines Act are not regulated in the same way that other products are regulated.
113. If the Order is retained and approvals of existing products are restricted, it could be seen to be an interference with an open and competitive market.

#### *Implications of allowing a private market for tests*

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

115. False-negative test results cause people to falsely believe that they do not have COVID-19, which poses health risks for the individual themselves and the risk of behaviour that further spreads the virus.
116. False-positive test results cause people to self-isolate unnecessarily, which can cause social and financial hardship.

### Equity considerations

117. If cheaper, less effective products are available on the private market, then it would disadvantage those who are more deprived. This is because they would need to either:
- spend their limited money on expensive tests that provide more reliable results, or
  - choose not to test and risk suffering health impacts from being unaware they have COVID-19 or spreading the virus to their whānau, or
  - purchase cheaper, less effective tests, and subsequently risk suffering poorer health and hardship, from which they already disproportionately suffer in virtue of being highly deprived.
118. This equity risk can be mitigated by ensuring that free RATs and PCR testing remain available and accessible for priority populations.

### Endnotes

<sup>1</sup> COVID-19 Modelling Aotearoa, ordinary differential equation model, December 2022

<sup>2</sup> [https://www.esr.cri.nz/assets/HEALTH-CONTENT/COVID-Genomics-Insights-Dashboard-CGID/CGID\\_35\\_Report.pdf](https://www.esr.cri.nz/assets/HEALTH-CONTENT/COVID-Genomics-Insights-Dashboard-CGID/CGID_35_Report.pdf)

<sup>3</sup> Bhat, S, et al. 2022. *Ethnic Disparities in CT Aortography Use for Diagnosing Acute Aortic Syndrome*. Radiology: Cardiothoracic Imaging. Vol 4, No 6.

<sup>4</sup> Lee, C, Duck, I, Sibley, C. 2017. *Ethnic inequality in diagnosis with depression and anxiety disorders*. The New Zealand Medical Journal. Vol 130, No 1454.

<sup>5</sup> Atatoa-Carr, P, et al. 2008. *Rheumatic fever diagnosis, management, and secondary prevention: a New Zealand guideline*. The New Zealand Medical Journal. Vol 121, No 1271.

<sup>6</sup> Lennox, N, Kerr, M.P. 1997. *Primary health Care and people with an intellectual disability: the evidence base*. Journal of Intellectual Disability Research. 41(5). 365-372

<sup>7</sup> Beange, H, Bauman A. 1990. *Caring for the developmentally disabled in the community*. Australian Family Physician, 19, 1558-1563.

<sup>8</sup> Wilson, D, Haire A. 1990. *Health Care Screening for people with mental handicap living in the community*. British Medical Journal, 301, 1379-1381.

<sup>9</sup> Xie Y, Xu E, Bowe B, Al-Aly Z. Long-term cardiovascular outcomes of COVID-19. *Nat Med*. 2022;28(3):583-590. doi:10.1038/s41591-022-01689-3

<sup>10</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandselfisolationaftertestingpositiveinengland/17to26march2022>

<sup>11</sup> <https://www.afr.com/policy/health-and-education/new-data-shows-the-state-hospital-systems-under-most-covid-stress-20220721-p5b3db>

<sup>12</sup> <https://www.courtsofnz.govt.nz/assets/7-Publications/COVID-19-coronavirus/Protocols/20221019-Expiration-of-Epidemic-Notice-impact-on-Court-operations.pdf>

<sup>13</sup> Keske Ş, Güney-Esken G, Vatanserver C, et al. Duration of infectious shedding of SARS-CoV-2 Omicron variant and its relation with symptoms. *Clin Microbiol Infect*. 2023;29(2):221-224. doi:10.1016/j.cmi.2022.07.009

<sup>14</sup> <https://www.health.govt.nz/publication/covid-19-mortality-aotearoa-new-zealand-inequities-risk>

<sup>15</sup> <https://www.health.govt.nz/publication/covid-19-mortality-aotearoa-new-zealand-inequities-risk>

<sup>16</sup> <https://www.health.govt.nz/publication/covid-19-risk-among-disabled-people>

<sup>17</sup> <https://www.tewhatauora.govt.nz/whats-happening/work-underway/infection-prevention-and-control>