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MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Adapting the Ministry of Health's COVID-19 Strategy to prepare for and manage Omicron

Date due to MO:	17 January 2022	**Action required by:**	18 January 2022
Security level:	IN CONFIDENCE	**Health Report number:**	20220036
To:	Hon Chris Hipkins, Minister for COVID-19 Response		
Copy to:	Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
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Minister's office to complete:

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☐ See Minister's Notes	☐ Withdrawn	

Comment:

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Adapting the Ministry of Health's COVID-19 Strategy to prepare for and manage Omicron

Security level:	IN CONFIDENCE	**Date:**	17 January 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose of report

1. To inform you of the Ministry of Health's updated COVID-19 Strategy to prepare for and manage the Omicron variant.

Summary

2. The Ministry of Health has updated it's COVID-19 Strategy in response to emerging evidence and international experience with the Omicron variant. The overarching goal and principles of the strategy remain unchanged, and revisions are primarily focused on ensuring that we can keen Omicron out of New Zealand for as long as possible and respond quickly when it does arrive. Key components of the Strategy include:
   a) initially seeking to keep Omicron out of the community while we prepare our community protections (for example, via boosters) and testing, tracing, isolation and quarantine system,
   b) stamping out any small-scale incursions that may occur to avoid a widespread outbreak if at all possible,
   c) swiftly moving to either a 'Red' or a bespoke 'Red Plus' setting nationwide under the Covid Protection Framework to flatten the curve of any Omicron outbreak,
   d) rapidly shifting our resources to manage the impact of an Omicron outbreak while protecting those most at risk of severe illness, and
   e) moving back into 'pandemic as usual' management approach once we are past the peak of the outbreak, including ongoing regular Community Protection Framework assessments and changes to settings across the country as required.
3. The strategy stages are not necessarily mutually exclusive. For example, it is possible to both try stamp out a small-scale incursion while simultaneously moving to 'Red' or 'Red Plus'.

4. The strategy will also be supported by a series of 'pillars' or workstreams that come into effect when a public health risk assessment has concluded that containment of Omicron is no longer viable. Planning for such a strategic pivot is already underway across the pillars, which include:

   a) ***Testing, tracing and isolation***- Preparing the Testing, Tracing, Isolation and Quarantine model for a widespread Omicron outbreak by developing protocols to shift towards greater use of Rapid Antigen Testing and changing the exposure definitions used for contact tracing purposes,
   b) ***Health workforce*** - We are working on a range of measures with the Health Sector to enable us to retain capacity in the event of a widespread Omicron outbreak
   c) ***Care in the community*** - Updating the Care in the Community model to ensure that therapeutics are distributed to those most in need,
   d) ***Reconnecting New Zealand*** – Considering our border settings and the optimum time to commence travel on the Medium Risk Pathway under the Reconnecting New Zealanders with the World programme given the risk presented by Omicron.

Recommendations

We recommend you:

a)	**Note** that the Ministry of Health has updated it's COVID-19 Strategy in response to international evidence and emerging experience on the Omicron variant	**Noted**
b)	**Note** that there is a risk of a widespread Omicron variant outbreak across New Zealand given more people arriving who are infected with this variant, though this risk may reduce as the outbreaks overseas wane	**Noted**
c)	**Note** that, while evidence suggests it is less severe (in terms of hospitalisation and mortality rates), the Omicron variant is significantly more transmissible than Delta, and 2 doses of Pfizer are likely to be insufficient protection against transmitting the virus to others to prevent widespread outbreaks	**Noted**
d)	**Agree** that since the CPF framework was developed specifically in the context of Delta, it is timely to now review the framework to ensure that all the necessary public health measures are in place to mitigate the specific risks associated with Omicron, especially given the centrality of vaccination to the different CPF settings	**Yes/No**
e)	**Note** that you are meeting with the Prime Minister and other Ministers on Tuesday 18 January 2022	**Noted**
f)	**Agree**, when you meet with the Ministers above, to discuss the proposed updated strategy set out in this report	**Yes/No**

g) **Discuss** the Ministry of Health's updated COVID-19 Strategy with your colleagues **Yes / No**

Dr Ashley Bloomfield
Te Tumu Whakarae mō te Hauora
Director-General of Health
Date: 17.01.2022

Hon Chris Hipkins
Minister for COVID-19 Response
Date:

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Adapting the Ministry of Health's COVID-19 Strategy to prepare for and manage Omicron

Context

1 As of 16 January 2022, Omicron is now present in more than 149 countries. While we have successfully largely kept Omicron at the border to date, the risks of incursions appear to be growing. For example, there are now many Omicron presentations at the border (309 imported cases reported in the last fortnight).

2 There have also been two small scale community incursions of Omicron which appear to have been quashed successfully. This has given us precious time to better understand Omicron, allowing us to collect and adapt our response. This memo draws on the emerging international evidence to inform our proposed updated COVID-19 strategy in light of Omicron. A third community case, involving an MIQ worker, is currently being managed.

Evidence around the Omicron challenge

3 The Omicron variant has very different characteristics to Delta. It is:

a) *More transmissible* - Omicron is much more transmissible than Delta. Evidence from Australia is that case numbers are doubling every 2 to 4 days.

b) *Cases present differently* - a highly vaccinated population can result in a higher rate of asymptomatic illness or people experiencing symptoms that they might not attribute to COVID-19. This can result in fewer people coming forward for testing which in turn can make the virus more difficult to track and contain.

c) *Less severe for most people* – Evidence suggests Omicron causes less severe illness, in terms of risk of hospitalisation and fatalities, than Delta, even more so for those who are vaccinated. For example:

- Risk of hospitalisation with Omicron was found to be around one third that of Delta (UK Health Security Agency),
- Data from Denmark, South Africa, Canada and Scotland also suggests reduced hospitalisation risk, and
- Despite hospitalisations increasing in countries with high case numbers, death rates don't appear to be climbing, indicating a much lower mortality rate,

d) *Unclear how it impacts on the most vulnerable* - There is very little data available on severity for people and communities at higher risk of negative health outcomes. This suggests the need for a precautionary approach given the disproportionate burden of disease borne by these groups usually.

Evidence around effective interventions

4 The Ministry has reviewed the international evidence on effectiveness of third dose vaccinations, or 'boosters' for protecting against infection, symptomatic disease, and severe illness due to Omicron. The review found three doses of Pfizer vaccine appears to provide good protection against Omicron, albeit the evidence is still emerging. This holds true for protection against infection, symptomatic disease, and hospitalisation:

a) *Three doses of Pfizer have a vaccine effectiveness (VE) against Omicron infection of around 55-63% and then that wanes over the coming months.*

b) *UK data on Pfizer vaccine effectiveness for symptomatic disease for three doses against Omicron suggests around 70% effective protection from symptoms initially and around 50% effective protection 2.5 months after the booster.*

c) *Evidence suggests that three doses provide substantial protection against hospitalisation. Current estimates are that the VE against hospitalisation for Omicron (3 dose, Pfizer) is approximately 88-94%, even after waning and even in older populations, over 65 years.*

International Response to Omicron

5 Different countries have tried a range of strategies to combat their Omicron outbreaks. These have included, for example:

a) *Entry requirements* - Many countries implemented strict entry requirements in response to Delta in 2021. These measures have been retained and/or increased in light of the introduction of Omicron. For example, the USA now requires all foreign entrants to have undertaken a COVID-19 test one day prior to entry. However, Omicron is still circulating widely in the USA.

b) *Booster shots* – the introduction of Omicron has created an imperative internationally for rolling out booster shots in countries that have already fully vaccinated their populations.

c) *Lockdowns* – The Netherlands and parts of China have done this. There is currently no available evidence to suggest that lockdowns have been successful for 'flattening the curve' with Omicron.

d) *Gathering restrictions* – Germany has braced for a possible Omicron wave by introducing new restrictions on private gatherings and prohibiting large events. There is also a 14-day quarantine period there for people who have tested positive, which is under review given the burden on the healthcare sector and other essential service sectors affected (eg police and fire services). The effectiveness of these measures is unclear so far.

e) *Let the virus run its course* – while there is evidence that Omicron is milder than Delta, the World Health Organization (WHO) has warned that it should not be treated as mild, particularly since some people, particularly those at-risk, can be severely impacted, resulting in hospitalisation and death. In the USA, there has been modelling suggesting that a laissez faire approach will lead seven states, including California and Texas, to exceed their hospital capacity in the next week or so.

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Updated COVID-19 Strategy for Omicron

The need for decision-making speed and agility

6 Omicron's rapid spread has placed major burdens on health systems around the world. So, while we should do everything possible to keep Omicron out and stamp out small outbreaks, we must also prepare now to 'manage it' if there is a widespread outbreak in New Zealand. The success of our proposed strategy at Figure 1 below relies on flexibility and quick decision-making.

7 Advice from the Office of the Director of Public Health is that we are likely to have about a 2-week window (based on overseas data) until we reach the high prevalence model. In this context, once we know there is secondary transmission, we will need to be ready to move stages more or less immediately. This matters in terms of providing the Ministry, the health sector and rest of government time to transition into the new model before Omicron becomes widespread. For example, we need time to enact Business Continuity Plans and switch from our current intensive approach to Testing, Tracing, Isolation and Quarantine (TTIQ) to one that is much more targeted.

8 To enable the necessary decision-making speed, we are proposing that decisions about if, and when, to move between phases will be on the basis of either 'as needed' urgent Public Health Risk Assessments or our usual COVID-19 Protection Framework (CPF) assessments (if an Omicron incursion happens to coincide with when we have one scheduled). Such an assessment will be triggered in the usual manner, relying on the existing links between our Incident Management Team Functions and Office of the Director of Public Health.

9 The decision to move between the stages below will depend on the specifics of the outbreak involved. However, as with our efforts to deal with previous COVID-19 outbreaks there are criteria we can use to determine advice for triggering the shift to different stages. These decisions are likely to include consideration of:

a) *Recency of community exposure* – for example, the period Omicron has been circulating in the community,

b) *Number and nature of exposure events* – for example, whether there has been a single event or multiple and/or super spreader events, and/or

c) *Number of cases* – for example, 1-10 might be containable using tracing, testing and isolation, more than 20-30 may not be.

10 The overarching goal and principles remain unchanged. However, our strategy needs to be both flexible and fast enough to enable a different response depending on a rapidly evolving situation with respect to Omicron.

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Figure 1: Overview of updated COVID-19 Strategy for managing Omicron

Goal	Minimise hospitalisations and deaths				
Principles	• Equity – Protect at risk communities and individuals • Sustainability – ensure health system can sustain response to COVID-19, while continuing to deliver non-COVID healthcare effectively • Agility – adapt our approach and actions as needed				
Omicron situation	None in community	1-2 cases in community	Growing community cases	Widespread community cases	Past Peak Omicron
Stage	**Prepare, plan & vax**	**Stamp it out**	**Flatten the curve**	**Manage it**	**Recover**
Actions	• Maintain entry requirements • Retain strong push on vaccinations, particularly for at risk • Prompt roll out of boosters, with focus at risk and 5-11s • Update CPF to take account of Omicron • Prepare health/welfare system to support most at risk • Ensure Māori and Pacific providers resourced for community support	Respond rapidly to minor incursions with aim of stamping out before Omicron widespread • Rapid testing, tracing and high support isolation • Introduce localised lockdowns if appropriate	Slow the growth • Move immediately to Red; or • Move to 'Red Plus': • High risk gatherings not permitted (e.g. night clubs) • Gathering sizes reduced • Mask use indoors • Business and hospitality guidelines • Start TTIQ strategy	Embed TTIQ strategy, including • Streamline contact tracing and digitise allowing rapid identification of those who need to isolate • Reserve PHU resources for high-risk events and settings • Activate health system resilience plans with focus on community care, triage and access to emergency care • Automate welfare system responses so that those isolating at home have money, food and medication • Finalise pathways for access to therapeutics which may reduce disease progression	Return to 'pandemic as usual' management • Downgrade from Red to Orange • Reinstate deferred Health services
Comprehensive communications strategy that helps public understand & respond at each stage					

11 The figure above implies taking a flexible and responsive approach and includes:

a) seeking to keep Omicron out of the community while we prepare our community protections (for example, via boosters), and waiting for outbreaks in other countries to wane.

b) if required, stamping out any small-scale incursions that may occur to avoid a widespread outbreak if possible and swiftly move to a 'Red' or a bespoke 'Red Plus' setting under the CPF to flatten the curve of any Omicron outbreak,

c) if Omicron becomes widespread, rapidly shifting our resources to manage the impact while protecting those most at risk of severe illness, and

d) once we are past the peak of the Omicron outbreak, moving back into 'pandemic as usual' management approach, including ongoing regular CPF assessments and changes to colours across the country as required.

e) The strategy will be supported by a series of 'pillars' or workstreams that are already underway.

Pillars of the response to manage Omicron

12 The strategy will be supported by a series of 'pillars' or workstreams that are already underway. The focus of work under each pillar will need to adapt, depending on which of the five stages of the strategy we are in.

Testing, tracing, and isolation and quarantine

13 On 11 January 2022 Minister Verrall was provided with an interim Testing, Tracing, Isolation and Quarantine Public Health model for consideration (HR20220001 refers). The model considers how testing, tracing, isolation and quarantine will need to change as an outbreak of Omicron progresses.

14 Key changes include a shift to Rapid Antigen Test (RAT) testing becoming the primarily diagnostic tool once an outbreak is advanced and changes to isolation and quarantine periods and case definitions for contact tracing purposes.

15 The Ministry had 3.5 million RATs in stock with its logistics provider as of 7 January 2022 with more arriving each day. We have front loaded orders of 17 million RATs for delivery over January and February 2022 and monthly deliveries of 4 million from March 2022 onwards. Further orders are in the process of being progressed for delivery in January and February with the aim of reaching a target of 40 million available RATs to further strengthen supply should an outbreak occur.

Workforce

16 We are working on a range of measures with the Health Sector to enable us to retain and redeploy capacity in the event of a widespread Omicron outbreak. This includes re-deploying staff from elective treatments, use of vaccination and testing staff and those on the Hospital database. We are also exploring whether it is possible to use health students as healthcare assistants in hospitals and training and development opportunities for non-clinical workers who could be redeployed to support essential services and roles.

17 We are also continuing to build our workforce capacity and capability, including:

a) prioritising workforce initiatives that support Māori health outcomes,

b) supporting holistic models of care to minimise transmission and prevent hospitalisations, ICU care and deaths, and

c) developing measures to encourage and support clinically qualified practitioners to re-join the regulated workforce.

18 As part of the above efforts, we are investigating approval mechanisms to enable the unregulated workforce to perform basic healthcare services, as appropriate to their skills, experiences, and training. This workforce includes kaiawhina and undergraduate and post-graduate students from clinical and non-clinical courses.

19 We are also considering capacity-building efforts that can be started now but may take longer to result in additional workers, including:

a) broadening recruitment sources by reviewing existing talent pool databases, including Hands Up and KiwiHealth Jobs to streamline the recruitment process for employee candidates and employers, and

b) identifying and developing ways to use the internationally qualified "in-training" workforce sources that currently exist in New Zealand.

Care in the community

20 The current Care in the Community model can provide high quality care to people diagnosed with COVID-19. District Health Boards are engaged with Iwi and other primary

care providers to operationalise Care in the Community hubs. We are confident that relationships are well established locally and that clinical care providers have access to assessment tools that enable them to stream people into the appropriate care pathway.

21 Given the likely pace and scale of a widespread Omicron outbreak, the current care in the community system is unlikely to be able to provide the same high-level of care for people required to isolate. To retain an intensive clinical care pathway for those with the greatest need, a self-service model is being designed to protect capacity. This is being built on the following principles:

a) it will be equity focused, ensuring that those with the greatest risk will be able to access the level of clinical care they need,

b) non-digital support will be available for those who are unable to access digital platforms,

c) those that can safely self-manage at home will have a range of guidance to enable them to do this, including instructions on how to access emergency assessment should their condition deteriorate at any time.

22 Novel therapeutics for COVID-19 that can be used in the community to reduce the risk of hospitalisation, ICU admission and death are in the process of becoming available in New Zealand.[1] Planning is in place to develop implementation plans to rollout these therapeutics in the community including clear and considered guidance around where their use should be prioritised.

Reconnecting New Zealand

23 In response to the emergence of Omicron, Cabinet agreed in-principle to delay the reopening of the border to New Zealanders and other eligible travellers arriving from Australia (Step 1) to align the reopening with a greater proportion of the population having received a booster shot, which will likely be at the end of February 2022.

24 The domestic COVID-19 situation will have implications for the timing of all the Reconnecting steps. We are adapting our public health advice in relation to the Reconnecting New Zealand strategy to recognise the ongoing and cumulative risk associated with the rise of Omicron around the world. This includes potentially postponing the medium-risk pathways further. However, once Omicron is in the community, and the number of cases exceeds the number of cases presenting at the border, it will be difficult to justify keeping the borders closed to New Zealand citizens, as the public health rationale for doing so will be weakened.

[1] For example, the Monoclonal Antibody treatment casirivumab/imdevimab (Ronapreve) is currently undergoing the approval process with MedSafe who are awaiting further information from Roche. The initial delivery of 4,800 doses is due to arrive in the country within the next week.

Regarding oral antiviral treatments, the MedSafe approval process for Phizer's oral protease inhibitor is underway and Pharmac's COVID-19 Therapeutic Technical Advisory Group met in late December 2021 to consider the groups that could be eligible for it.

Rationale for our proposed approach

We lose little by seeking to keep out, then stamp out, Omicron initially

25 It may not be possible to keep Omicron out of the community for very long. However, our success in delaying entry of other variants suggests that seeking to first delay, then slowing the progress of COVID-19 may be very helpful. As outbreaks in other countries wane, it also reduces the risk of importing a case.

26 New Zealand is in a strong position relative to most other countries around the world. This is likely for a range of reasons, including our geographical isolation and our policies to date (for example, to pursue high levels of vaccination and virus containment as long as possible so far). We have also already managed to contain two previous Omicron incursions into the community; with a third community case currently being managed.

27 Even if we do ultimately experience a widespread Omicron outbreak, the proposed graduated approach may buy us more time for further planning, preparation and vaccination prior to a wider outbreak. For example, evidence from all previous outbreaks suggests that boosting vaccination rates early and preparing well to care for priority populations will help lessen the ultimate impact of any such outbreaks.

We can use the time to focus on increasing vaccination levels and to prepare for Omicron

28 **Boosters:** as indicated above, international evidence suggests that boosters may play a key role in helping us reduce the potential impact of a widespread Omicron outbreak. If we can avoid such an outbreak for a further 1-2 months, this could allow time for substantial improvements in booster vaccination rates, potentially meaningfully reducing the disease burden. With around 600,000 New Zealanders having already received their third dose of the Pfizer vaccine, we are already better placed than many other countries.

29 **Capacity:** the system capacity for COVID-19 vaccinations has proven to be able to scale up quickly, and we are confident that we can deliver vaccination for those who are currently eligible for a booster. However, there are potential risks that need to be factored into broader planning – including supply limitations, shared workforce across vaccination and testing, and equity.

30 **Supply:** to deliver a booster programme for the total eligible population four months following the primary course, New Zealand will require an additional 1.25 million doses through February and March 2022. These doses would complement our existing Pfizer delivery schedule and ensure that we could offer booster doses to all eligible New Zealanders by 30 June 2022. These supply limitations pose risks for the ability to deliver boosters to the entire eligible population.

31 **Workforce:** Currently we have immense capacity in the vaccination programme. However, if Omicron is widespread in the community it will result in workforce displacement as many working in the vaccination system also work in other parts of the health system (such as nurses). Approximately 60 percent of COVID-19 vaccinations are delivered by primary care and pharmacy providers.

32 **Delivery:** there are delivery risks for vaccination if there is a need to prioritise access to primary care/pharmacy support, iwi/Māori provider support, and access to clinical advice. There will need to be clear decision-making criteria and communications to the sector and the public regarding priorities for the workforce.

33 **Testing:** once Omicron is in the community, we may need to change our approach. It will be important to ensure that our focus on vaccination does not come at the cost of testing. Testing will need to increase initially as we seek to identify and respond to any community incursion as fast as possible.

Equity

34 As outlined above, if and when Omicron does spread across the country, it is likely to lead to reasonably mild levels of illness for most people (i.e. not requiring hospitalisation). However, as with Delta, there remains significantly higher risk for some sections of the New Zealand community (those we call 'priority populations'). This includes those who are not yet vaccinated, or not sufficiently, older people, people with co-morbidities, lower socio-economic groups, and those who live far from healthcare. These risk factors disproportionately affect Māori and Pasifika communities, and people with disabilities.

35 The proposed strategy seeks to protect these groups initially by doing everything we can to 'keep it out' and 'stamp it out'. Additionally, the Ministry has been working to support communities with high numbers of at-risk people so that they are able to better respond to COVID-19 in the community. This has involved drawing on the Māori Communities COVID-19 Fund (MCCF).

Treaty of Waitangi

36 Engagement with Māori on the Omicron Strategy and its operationalisation will be necessary for the Crown to meet its Tiriti obligations in the response to Omicron. The engagement with Māori has already involved Minister-led meetings with the National Iwi Chairs Forum, various Tāmaki and iwi stakeholders, and most recently with the NZ Māori Council and co-claimants in the Haumaru inquiry.

37 Increasing Māori vaccination rates, including boosters, is the key protective step that can be initiated to protect Māori communities against a future Omicron outbreak. While Māori vaccination rates are increasing, they are still lower than non-Māori rates – most notably in areas where there are more barriers to accessing healthcare and other resources that will be needed in a widespread outbreak.

38 Given the emerging data on boosters for both symptomatic disease and hospitalisation, continued focus on achieving high 3-dose vaccination rates for Māori communities will be imperative to reducing the burden on Māori communities, and reducing the burden on the whole system. The paediatric vaccine rollout also presents an opportunity to protect our most at-risk communities by both protecting tamariki Māori and as a mechanism to engage with the rest of the whānau.

39 Initiating further protections now may help prepare Māori communities and enable local responses to Omicron community incursion. This includes exploring whether the policy on boosters (four months after second jab) should be shifted to a shorter timeframe for Māori, and providing targeted communications on preparation for managing COVID-19 at home.

40 If and when we move from 'stamp it out' to later stages, additional support and dedicated focus will be required for those who remain unvaccinated or partially vaccinated, remote communities, and those with limited access to primary health and community services, ambulances, and hospitals. Our experience with Delta has clearly shown that whānau Māori

support needs increase significantly during community transmission, due to factors such as crowded housing making isolation within a household difficult.

41 A whānau ora approach where providers provide holistic care (ie encompassing both health and welfare needs) will need to be supported by non-Māori services to enable effective engagement with Māori in a medium to high scenario when both Māori providers and Public Health Units will be stretched.

Communications

42 Clear and consistent public messaging remains a critical element of New Zealand's COVID-19 response to maintain social licence, cohesion, and to ensure New Zealanders have the information they need to take appropriate action. A focus on public readiness, preparedness and self-reliance will require early nuanced and clear messaging. This will help ensure the public are motivated and empowered by knowing what they need to do and understanding and accepting the rationale on which it is based.

43 A comprehensive communications plan has been developed containing key messages. In terms of the public, these messages include:

a) New Zealand has done very well at responding to and managing COVID-19,

b) we have one of the lowest death rates in the world, few cases and high rates of vaccination,

c) we have in place a plan to manage Omicron, if and when it enters our community, and are ready to move quickly if needed, and

d) we need you to get prepared for this new phase in this pandemic. Your best protection remains being fully vaccinated including being boosted, staying home and getting tested if unwell, maintaining good hygiene, and protecting the vulnerable members of your whanau.

44 We will also continue to coordinate across agencies to communicate and engage using the established Unite Against COVID-19 channels. Alongside this, specific messages will be provided to the wider health sector to ensure that everyone understands our overall strategy and is clear when we are potentially shifting between phases.

45 We propose a three phased approach to communicating Omicron:

a) Phase I: Prepare and frame - this began with the move to the CPF and will move to individual and community readiness. Campaigns already in market to encourage public health behaviours will need to be expanded and adapted to focus on the management of Omicron.

b) Phase II: Plan and enable - this will outline changes and explain the rationale for changes to Testing, Tracing, Isolation and Quarantine, the Community Protection Framework, Reconnecting New Zealand, border settings, and any updates to sector guidance. It will also begin to normalise subsequent boosters if these are indicated and the ongoing nature of adapting to changes in COVID-19.

c) Phase III: Respond – action-oriented communications to assist communities to respond and continue to have trust and confidence in the response.

Next steps

46 You are meeting with the Prime Minister and other Ministers on Tuesday 18 January to discuss the Omicron variant and vaccines. You may wish to draw on the content of this briefing to support you in this discussion.

47 Officials are also available to discuss the updated strategy with you and to provide further information on any areas of interest.

ENDS.

Document 3

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Readiness to shift to Phase Two of the Omicron response plan

Date due to MO:	4 February 2022	**Action required by:**	7 February 2022
Security level:	IN CONFIDENCE	**Health Report number:**	20220128
To:	Hon Chris Hipkins, Minister for COVID-19 Response Hon Andrew Little, Minister of Health Hon Dr Ayesha Verrall, Associate Minister of Health		

Contact for telephone discussion

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Maree Roberts	Deputy Director-General, System Strategy and Policy	S9(2)(a)

Minister's office to complete:

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

Comment:

Document 3

Readiness to shift to Phase Two of the Omicron response plan

Security level:	IN CONFIDENCE	**Date:**	4 February 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response Hon Andrew Little, Minister of Health Hon Dr Ayesha Verrall, Associate Minister of Health		

Purpose of report

1. This report outlines preparatory work by the Ministry of Health (the Ministry) to support a potential shift to Phase Two of the Omicron response plan (refer **Appendix 1**) in the coming days. It also recommends that the Red 'traffic light' settings under the COVID-19 Protection Framework (CPF) remain unchanged.

Summary

2. On Tuesday 1 February 2022, the Ministry conducted a public health risk assessment (PHRA) to assess whether to move from Phase One to Phase Two of the Omicron response plan and reviewed the current CPF settings.

3. The PHRA considered the trajectory of the outbreak and likelihood that cases will continue to increase based on evidence that there is undetected community transmission. Over the past week, up to and including Wednesday 3 February 2022, there have been 613 cases reported with a seven-day average of 87 cases per day.

4. In this context, the current Red CPF setting remains appropriate until further review. At this stage it is not considered necessary to reduce capacity/gathering limits for events and venues under the Red setting, but this may be reconsidered in the future if the Omicron outbreak grows significantly.

5. With the expected increase in cases, the health and wider All-of-Government (AOG) COVID-19 response system is preparing to move to Phase Two of the Omicron response plan in the coming days. This work is well advanced but there remain areas that require further work.

6. An assessment of operational readiness by the Ministry in recent days has shown that the health sector is prepared for a shift into Phase Two. From day one, the shift to new ways of operating will be evident. However, some components do involve a minimum lead-in time to be fully implemented as Phase Two goes live.

7. I will advise when, from an outbreak and health system perspective, it is appropriate to transition to Phase Two. At present, Phase One remains appropriate but a shift to Phase Two can be made rapidly if the outbreak grows significantly.

Recommendations

I recommend you:

a)	**Note** that the Ministry of Health conducted a public health risk assessment on Tuesday 1 February 2022 to consider the timing of a shift from Phase One to Phase Two of the Omicron response plan, and whether it is appropriate to remain at Red under the current COVID-19 Protection Framework settings.	**Noted**
b)	**Note** my advice that all parts of New Zealand remain at the Red setting of the COVID-19 Protection Framework until further review, due to the current Omicron outbreak and increasing case numbers across New Zealand.	**Noted**
c)	**Note** my advice that gathering limits at the Red setting of the COVID-19 Protection Framework should remain unchanged at this time but are kept under review as the Omicron outbreak evolves.	**Noted**
d)	**Note** that preparations are well advanced across the health system to ensure we are ready to transition to Phase Two of the Omicron response plan rapidly if needed.	**Noted**
e)	**Note** that some operational readiness components (refer Appendix 2) will involve a short minimum lead-in time once the decision to shift to Phase Two of the Omicron response plan is made to ensure a smooth transition.	**Noted**
f)	**Note** that the Ministry of Health is working closely with district health boards to ensure they are ready to move to Phase Two of the Omicron response plan.	**Noted**
g)	**Note** I will provide you with further advice on when, from an outbreak and health system perspective, it is necessary for the Government to move to Phase Two of the Omicron response plan following a further COVID-19 public health risk assessment.	**Noted**

Dr Ashley Bloomfield
Te Tumu Whakarae mō te Hauora
Director-General of Health
Date: 4 February 2022

Hon Chris Hipkins
Minister for COVID-19 Response
Date: 8/2/2022

Document 3

Readiness to shift to Phase Two of the Omicron response

Background

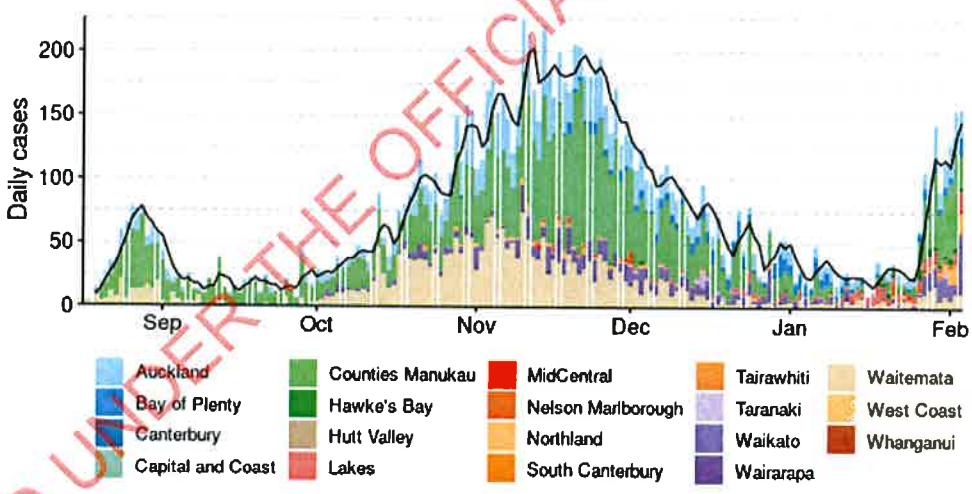
1. On Sunday 23 January 2022, Ministers with Power to Act moved all regions in New Zealand from the Orange to Red setting of the CPF in response to unlinked cases of Omicron in the community. The Associate Minister of Health then announced on Wednesday 26 January 2022 the Government's three-phase Omicron response plan.

2. Since the move to the Red setting of the CPF, COVID-19 case numbers have continued to increase. Over the past week, up to and including Friday 4 February 2022, there have been 797 cases reported with a seven-day average of 113 cases per day.

3. The epidemic curve (refer **Figure 1** below) shows cases reported in the previous three months. It shows the rise and fall of the Delta outbreak from November through to December 2021 and the current rise in cases reported in the end of January 2022, including Omicron cases.

4. The data is current as of Friday 4 February 2022 and includes both Delta and Omicron cases. The black solid line denotes the national three-day rolling average.

Figure 1 - Current epi-curve of cases reported in the previous three months by report date and DHB



Public health risk assessment

5. On Tuesday 1 February 2022, the Ministry conducted a PHRA to assess the current outbreak, including whether to move from Phase One to Phase Two of the Omicron response plan. The CPF settings were also assessed to ensure they are kept under regular review and that the restrictions are appropriately set.

6. The PHRA involved a comprehensive analysis and discussion of the Omicron outbreak, the current health system capacity and demand in each region, as well as key factors of whether to move from Phase One to Phase Two of the Omicron response plan.

7. Based on the available information, the PHRA recommended that:

   a. All parts of New Zealand should remain at the Red setting of the COVID-19 Protection Framework until further review.

   b. Capacity limits at the Red setting of the COVID-19 Protection Framework should remain unchanged at this time but be kept under review as required.

   c. The Health System and AOG COVID-19 response should be ready to transition to Phase Two by Friday 4 February 2022.

8. As part of the assessment, each district health board (DHB), coordinated by four Resilience Leads, assessed their respective capacity and projected demand to respond to COVID-19 over the next fortnight. The assessments considered a range of aspects including health care services and workforce and drew in intelligence from discussions the Leads conducted with community and Māori and Iwi providers.

COVID-19 Protection Framework settings

9. The PHRA assessed the current CPF colour settings. Based on the current situation of unlinked transmission of the Omicron variant in the community and the expected rise in cases, it was considered appropriate for the whole country to remain at the Red setting of the CPF until further review.

10. We know that large gatherings pose the highest risk of undetected transmission. A key feature of the Red setting is restrictions on gathering limits used in conjunction with COVID-19 Vaccine Certificates and other measures.

11. On balance, the PHRA considered that current gathering limits at Red do not need reducing at this time, as widespread community transmission has not yet been detected. However, it was suggested that this measure be re-considered if and when there is rapid and uncontrolled community transmission of the Omicron variant. There is a risk that changing settings prior to that scenario could lead to greater public uncertainty and would outweigh the benefits of more stringent measures.

Omicron response plan - shifting from Phase One to Phase Two

12. The Government's three-phase Omicron plan aims to slow down and limit the spread of an outbreak (refer Appendix One). It seeks to promote an equitable, sustainable, and agile health response to COVID-19, while continuing to deliver business-as-usual healthcare for New Zealanders.

13. The three phases are intended to provide an agile and sustainable response. This reflects the significantly greater transmissibility of Omicron and the likely need to manage widespread transmission as we have seen overseas.

14. The aim of Phase One is to 'stamp it out' or contain and eliminate local outbreaks quickly if possible. This phase is sustainable if containment remains plausible and the impost on the health system (including the contact tracing and testing systems) remains manageable. Phases Two and Three aim to 'flatten the curve' through measures that aim to minimise and slow further COVID-19 transmission and focusing on protecting the most vulnerable people.

15. There will come a point when the response must switch from containment to minimisation to deploy public health and health care resources most effectively while protecting those most at risk from poor outcomes due to Omicron.

Operational readiness assessment

16. The Ministry has undertaken an assessment of our operational readiness to shift from Phase One to Phase Two of the Omicron response plan. A summary of this assessment is set out in a table at **Appendix 2**. The key components of the operational response include policy and legal, testing, care in the community, case notifications and investigations, Healthline, isolation and quarantine and digital pathways.

17. This assessment has shown that the health sector is prepared for a shift into Phase Two. From day one, the shift to new ways of operating will be evident. However, some components involve a short minimum lead-in time to be fully implemented as Phase Two goes live, for example the new testing regime, involving rapid antigen tests (RATs), will be ready to go from 'day one' but will take up to five days to be fully implemented from the point of shifting to Phase Two.

18. At present, there are 4.4 million RATs in the central stock. There are approximately 1.8 million RATs held by service providers that are ready to be utilised once Phase Two goes live. A further 25.7 million RATs are on order to the end of February 2022, while 20 million are confirmed for delivery by then.

19. The Ministry has been working closely with DHBs to understand their preparedness for the transition. This includes seeking to understand their capacity to provide both business-as-usual healthcare services, and to respond to COVID-19 cases (including the growing number of Omicron cases). The establishment of regional governance and regional leadership arrangements last year has helped significantly to ensure that DHBs are working collaboratively, sharing best practice, and coordinating their activities effectively across regions.

20. As part of working closely with each other and with the Ministry, all DHBs have been completing a detailed checklist of their preparedness, covering nine domains. These domains include care in the community, workforce, leadership and governance, equity, and welfare support readiness. The questions also explore how ready each DHB is for a possible wider Omicron outbreak specifically.

21. Most DHBs report that they are significantly better prepared to manage such an outbreak than the last time they completed the checklist in December 2021. This is particularly in terms of their ability to deliver 'care in the community' services. Their reports-back also drew on ten selected DHB desktop reviews of their resurgence plans in December 2021.

22. There remain ongoing workforce pressures across the health system that will be exacerbated once there is greater demand on the healthcare system and as health care workers are required to isolate as cases or contacts. This will be most acute for the health workforces caring for at risk communities for example Māori, Pacific, and those with disabilities, as well as the rural health workforce, which is already seriously stretched.

Care in the Community consumer pathways and risk stratification

23. Phase Two is designed to protect those most at risk of poor outcomes from COVID-19. It focuses resources increasingly on those with the greatest health and welfare needs, and those most at risk from poor outcomes due to Omicron.

24. This includes those who are frail and/or elderly, more socio-economically deprived and those who suffer from co-morbidities. Māori and Pasifika are likely to be disproportionately represented in these groups and to suffer disproportionately from a widespread outbreak.

25. As part of the Care in the Community programme, a consumer pathway process has been developed to support people during Phase Two (and Phase Three). The pathways identify those that can self-manage and those who will need greater levels of support and require active management. This will be activated as part of the transition to Phase Two and will become more important as case numbers increase. Active management of those most at risk is linked to a person's patient records which aims to minimise the risk that their specific health needs are not adequately met. This approach is outlined further at **Appendix 3**.

26. The consumer pathway recognises that in Phase Two (and Phase Three) there will be a bell wave of people wanting healthcare services. The pathway will ensure people can continue to access the health system and the services they need by targeting those most at risk during the outbreak, including, those who are digitally excluded. A critical component will be welfare support, which the Ministry of Social Development is responsible for delivering but strong collaboration will be vital.

27. A Risk Stratification tool is also being developed to identify those people who are most at-risk of negative health outcomes due to COVID-19 as well as being used as a planning tool for the health sector to inform resource allocations for tests, therapeutics, and workforce. The tool will provide a 'score' of an individual's need based on age, ethnicity and vaccination status, and is already part of the COVID Population Identification & Registration (CPIR) database. The score indicates whether a person is at higher risk of hospitalisation and in need of active care management or can manage their COVID-19 infection through the self-service pathway.

Rationale for timing of shift to Phase Two

28. As outlined in the summary above, advice for any potential transition to Phase Two of the Omicron response plan will follow a COVID-19 Public Health Risk Assessment. As outlined in the summary above, advice for any potential transition to Phase Two of the Omicron response plan will follow a further COVID-19 PHRA.

29. The following criteria will inform the Ministry's recommendation to move from Phase One to Phase Two of the Omicron response plan:

    a. *Cases:* Overall cases numbers and growth rates, and whether there were delays finding links between cases and/or a source for each outbreak.

    b. *Exposure events:* The number and nature of exposure events in any region, the type of activities that took place (e.g. close contact between people), and whether events involved a single exposure, multiple exposures, or a super-spreader event.

    c. *Contact tracing:* Capacity to effectively manage contacts, cases, and exposure events.

d. *Testing demand and supply:* The number of test results and positivity rates, supply, and laboratory capacity for processing PCR samples, including the volume of tests and the projected turnaround time.

30. I will advise ahead of the PHRA being conducted and the outcome, including the recommended timing of a transition to Phase Two based on the progress of the current outbreak and careful consideration of the criteria above.

Equity

31. We have learnt from previous outbreaks that equitable responses require the Ministry to work in close partnership with Māori and Pacific community and health organisations, such as providers. These organisations hold unique relationships with their communities and supporting them will be integral to mitigating severe health outcomes and lessening the impact of an outbreak on broader welfare needs.

32. Moving into Phase Two, DHBs will need to work with providers to ensure that care is given to those who most need it.

33. The Omicron variant is known to spread rapidly in the community meaning that a shift to Phase Two needs to be rapid when we reach a point of uncontrolled spread. We note that there may still be some lead times for certain functions to transition – such as processing the IT system changes required in relation to changed case and contact definitions. By ensuring DHBs are ready for this rapid shift, the health system will be able to provide tailored and targeted resources to at risk groups more efficiently.

Communication

34. A national communications campaign has been underway for approximately three weeks to gain public understanding and acceptance of the paradigm shift required in the management of COVID-19, due to the nature of Omicron.

35. The shift to the self-management model has been supported with a well-articulated call to action to ensure the public are ready, through having plans and provisions, and have been provided with enough information to help them understand and accept the rationale on which it is based. During this phase, communications have continued to reinforce the golden rules of mask, pass, scan, socially distance and maintaining good hygiene.

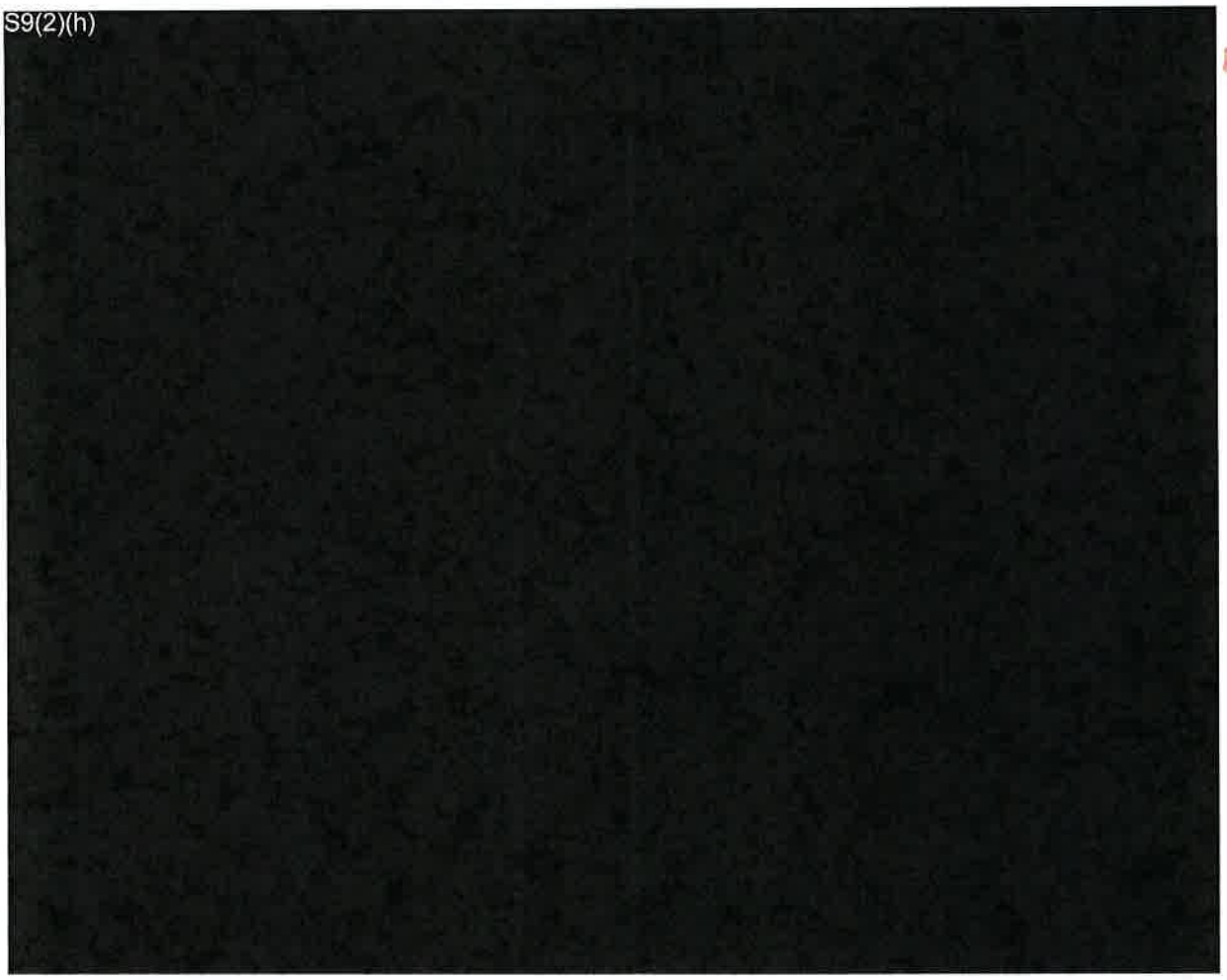
36. The messages have been delivered through many platforms, including media briefings by Ministers and myself as Director-General of Health, information across government agencies, on government websites, social media posts and channels and engagement with sectors and industry.

37. The Phase Two AOG communications plan is being provided to the next National Response Leadership Group meeting. This plan will outline the AOG activities to ensure the public (including consumer pathways) and sectors understand in detail the changes and settings during Phase Two.

38. A significant amount of collateral has been developed across agencies led by the Ministry, the Department of the Department of Prime Minister and Cabinet (DPMC) and the Ministry of Business, Innovation and Employment to support the shift to Phase Two and will be ready to use across all channels and platforms.

39. Some work is still required to ensure absolute consistency of messaging across all public channels. It would be preferable for agencies, including DPMC's Unite Against COVID-19 team to be given time to enable television commercials and radio ads to be booked and deployed once a decision is taken. In Phase Two, communications will be targeted heavily to priority populations, including those people with additional health or welfare needs, Māori, and Pacific peoples.

S9(2)(h)



Next steps

44. The Ministry will continue to assess the evolving COVID-19 situation and based on the current trajectory and evidence relating to Omicron, we anticipate that a shift to Phase Two of the operational response will be required within the next week. I will advise when those conditions have been met. The Ministry will also continue to keep the CPF settings under regular review.

ENDS.

Document 3

Appendix 1: Omicron response plan

Goal	**Minimise hospitalisations and deaths**		
Principles	• **Equity** – Protect at risk communities and individuals • **Sustainability** – ensure health system can sustain response to COVID-19, while continuing to deliver non-COVID healthcare effectively • **Agility** – adapt our approach and actions as needed		
Scenarios	**LOW:** There are some cases in the community, but containment appears possible	**MEDIUM:** Sustained and substantial spread of Omicron in the population	**HIGH:** Widespread community cases, possibly via multiple and/or super-spreader events
Objectives + approach	**Phase One:** Contain and eliminate outbreaks as quickly as possible	**Phase Two:** minimise and slow further spread and focus on protecting the most vulnerable	**Phase Three:** Move to self-management, protect vulnerable, preserve critical services and infrastructure by targeting resources
Rationale	Delay Omicron becoming widespread, buying time to vaccinate as many New Zealanders as possible and prepare the system to manage large numbers of cases	Reduce potential for harm by lessening overall numbers of cases, leading to less impost on primary care, hospitals and protecting most risk (by reducing probability of getting ill and ensuring priority access to care)	Protect and target primary care and hospital resources carefully and ensure most at risk receive priority access to care to protect from poor health outcomes. This includes ensuring the non-COVID health services can continue to be delivered.
Actions to give the strategy effect (across key work pillars)			
Testing	Intensive PCR testing to enable fast, highly reliable results and rapid isolation to help contain and eliminate outbreaks. PCR	Start shift from intensive PCR testing to RAT self-testing but keep PCR testing available to confirm diagnoses if needed. Allow people to return to	Focus PCR testing on priority populations only. Move to RAT testing for most others. Allowing people to return to work following a

	testing for symptomatic, close contacts, international arrivals.	work following a RAT if asymptomatic healthcare or critical worker close contacts.	RAT if asymptomatic healthcare or critical workers, who are close contacts.
Case investigation & contact tracing	Cases investigated as usual, using active management approaches (e.g. Health sector-led investigations). Push notifications (QR scanning), Bluetooth and locations of interest used to identify contacts.	Digital technology is utilised more as cases grow – e.g. text via mobile, self-investigation via online tools. Support available for those not digitally enabled. Start the shift from intensive Health-sector led investigations to self-investigations.	Full self-serve model – e.g. contacts automatically notified from online self-investigation and option for cases to self-notify their contacts. Only highest risk contacts will be traced and required to isolate. Limited use of push notifications, locations of interest or Bluetooth.
Isolation and quarantine	Cases isolate for 14 days. Contacts isolate for 10 days Extra support in place for health and critical workforces.	Cases isolate for 10 days. Contacts isolate for 7 days Extra support in place for health and critical workforces.	Cases isolate for 10 days. Contacts isolate for 7 days Extra support in place for health and critical workforces.
Health and social support	Clinical care delivered by primary care teams, supported by the local care coordination hub. Plan for shift to self-service. All steps taken to support positive cases to isolate in their usual place of residence.	Support for most positive cases to isolate in their usual place of residence. Alternative accommodation options across the regions are still available. Support by local care coordination hub for those with a need for ongoing clinical care. Begin shift to self-service.	Support for positive cases to isolate in their usual place of residence and alternative accommodation for cases that are unable to safely isolate at home. Majority of positive cases are self-management. Clinical care, wraparound health and welfare support focused on anyone with high-needs.
Comprehensive communications strategy that helps public (and health system) to understand & respond at each stage			

Document 3

Appendix 2: Summary of operational health readiness to shift to Phase Two of the Omicron response plan

Operational component	**What does the Ministry need to change to support a shift to Phase Two**	**Ready for Phase Two shift?** *(At 4 February 2022)*	**Preparation time** *(From 3 February)*	**Unavoidable lead-in time from Phase Two go-live**
Legal	Legal requirements for returning to work post infection.	Yes	Ready	Ready
	Legal mechanism for shifting to 10-day isolation period for cases and 7-day isolation period for close contacts.	Yes	Ready	Ready
	Legal mechanism for the use of RATs for symptomatic and close contact testing.	Yes	Less than 24 hours	Ready
DHB Readiness	All Regional and DHB resurgence plans.	Yes	Ready	Ready
Healthline	Training and deployment (both technology and training) of additional workforce to support surge capacity.	No but clear plan	5 days	24 hours (for re-rostering and training)
	Integration into the operating model of enhanced digital channels including self-service options.			
	Agreed process to support the allocation to DHB's of Care in the Community Telehealth support.			
Testing (Operational)	The use of RATs for people who are symptomatic and close contacts.	No but clear plan	5 days	24 hours

	Move ongoing asymptomatic surveillance testing to RATs for healthcare workers and discontinue other asymptomatic surveillance testing.		2 days	24 hours
	Enable 'test to return' to work if needed for asymptomatic critical workforce who are close contacts using RATs.		5 days	24 hours
Case notification investigations	End to end electronic pathway for notifications and self-investigation utilised.	No but clear plan	7 days	24 hours (*for minimum viable product*)
	Push notifications (through mandatory QR scanning). Bluetooth and locations of Interest used to identify contacts.	Yes	Ready	Ready
	NITC operations systems and processes.	Yes	Ready	24 hours
	Public Health Unit preparation for commencing operational changes.	Yes	Ready	48 hours
Isolation and Quarantine	Cases: Isolate for 10 days, self-release after day 10 if asymptomatic for 72 hours.	Yes	Ready	24 hours
	Close Contacts: isolate for 7 days since exposure and test on day 5.	Yes	Ready	24 hours
	Change in MIQ settings to align with 7-day close contact settings. (Note - this is for health staff to adjust to new settings but does not reflect the lead in time the wider MBIE-MIQ system requires at least three working days to implement a seven day stay after the decision is made).	Yes	48 hours	48 hours

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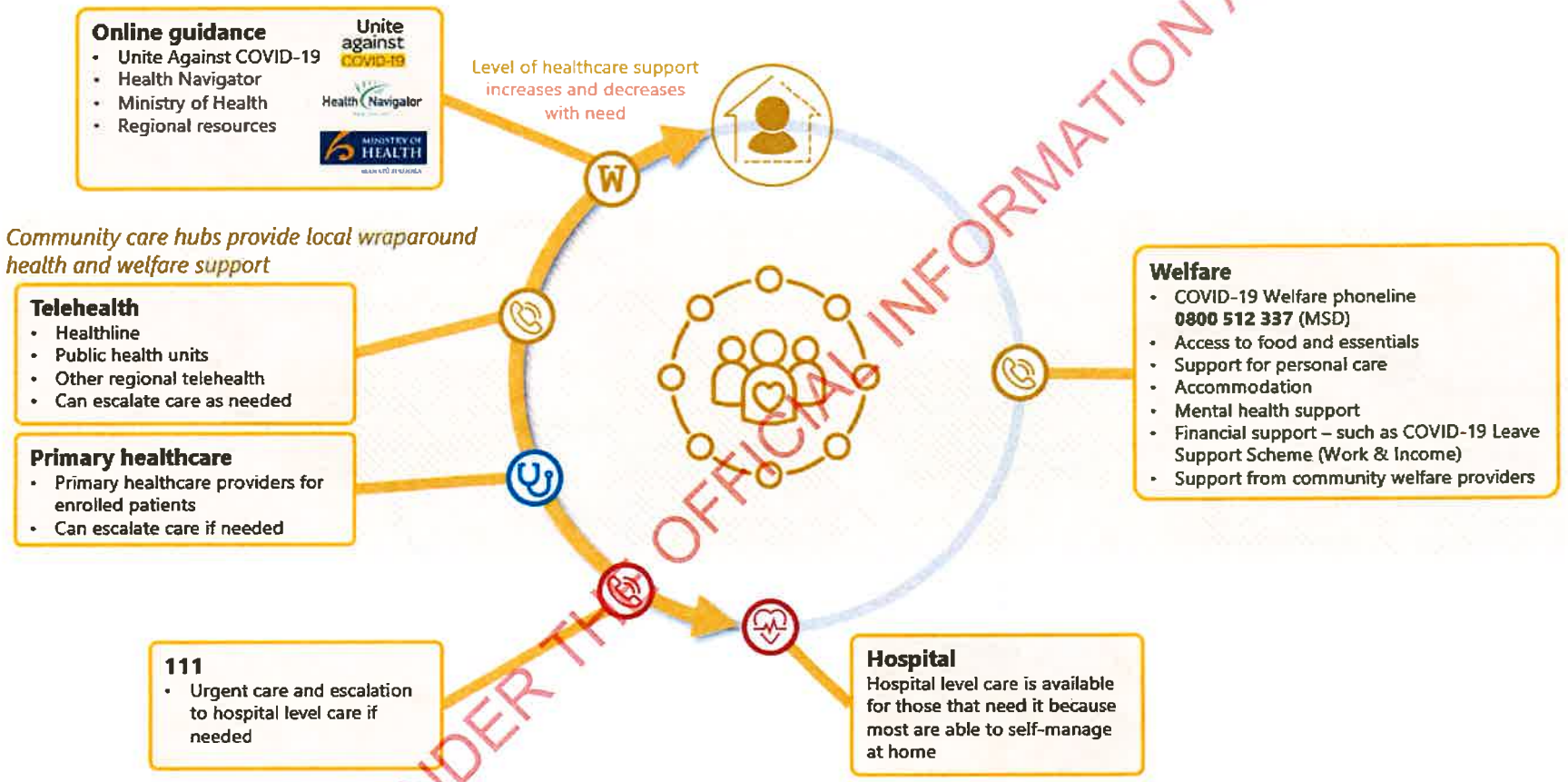
Care in the Community	Transition to cases using self-service and automation (all components included).	No but clear plan, under close watch	10 days	10 days
	Primary care teams deliver clinical care, supported by local care coordination hubs for those who require ongoing clinical care.	Yes	Ready	N/A
Digital pathways and enablers	Release self-assessment form to enable risk assessments.	Yes	Ready	Ready
	Automated positive test text message to consumers with links to self-service assessments (not essential for go-live)	No but clear plan	12 days (*scheduled for release 15 February*)	12 days
	Critical worker rapid antigen test ordering form available (not essential for go-live)	No but clear plan	6 days (scheduled for release 9 February)	6 days
	Pilot symptomatic self-reporting with Māori Health Providers.	Yes	Ready	Ready

Document 3

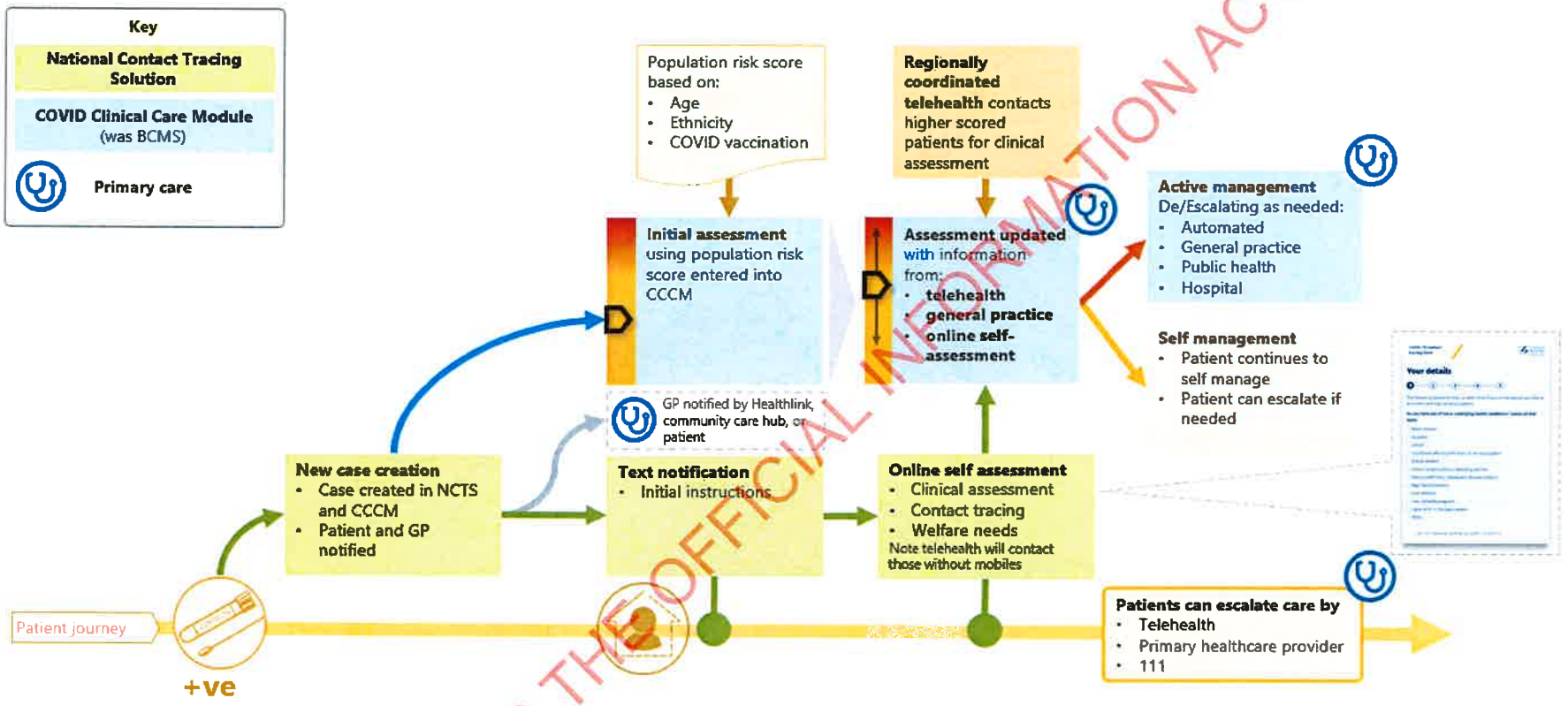
Appendix 3: COVID-19 Care in the Community and consumer pathways

Supporting the self-management pathway (as of 4 February 2022)



Document 3

Assessing and responding to clinical needs (as of 4 February 2022)



Document 4

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Options for a Bubble of One provision to operate from the commencement of phase 2 of our Omicron strategy

Date due to MO:	4 February 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220163
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
Dr Ashley Bloomfield	Director-General of Health	S9(2)(a)
Maree Roberts	Deputy Director-General, System Strategy and Policy	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Document 4

Options for a Bubble of One provision to operate from the commencement of phase 2 of our Omicron strategy

Security level:	IN CONFIDENCE	**Date:**	4 February 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response		
CC:	Rt Hon Jacinda Ardern, Prime Minister Hon Grant Robertson, Deputy Prime Minister Hon Dr Ayesha Verrall, Associate Minister of Health		

Background/context

1. To mitigate issues caused by Omicron-related absenteeism, Ministers have supported development of a Test to Return scheme. The scheme will enable critical roles within critical infrastructure and utilities workforces to return to work when considered a close contact, provided they are asymptomatic, have a valid vaccine pass and return a negative rapid antigen test (RAT) each day that they need to work throughout their isolation period (MBIE Briefing 2122-2475 refers).

2. To complement the Test to Return Scheme, Ministers have also indicated support for a 'Bubble of One' approach which enables a person to continue working regardless of their test status.

3. A Bubble of One provision would enable those who qualify to continue to work, in instances when they might otherwise be required to self-isolate at home, or only be able to return to work provided they return negative Rapid Antigen Tests (RATs) under the Test to Return scheme. It is anticipated that this would bring economic and well-being benefits to both individuals and the wider community.

4. The proposed provision would apply to workers who are unable to work from home and who are able to work in isolation from others. These workers would represent little or no risk of transmission of COVID-19 to others even if they are infected.

5. **Appendix 1** outlines a draft protocol for a Bubble of One provision that eligible workers would be required to follow (this has been approved by the Office of the Director of Public Health). As with the Test to Return scheme, workers would have to be asymptomatic and vaccinated to be eligible, and would have to adhere to standard isolation requirements when not at work – and would only become available from Phase Two.

Overview of options

6. Ministers have verbally indicated support for a Bubble of One provision. However, key details need to be resolved in relation to which categories of worker should be covered by the provision.

7. We have identified two categories of vaccinated, asymptomatic worker who meet a "working in isolation" criterion who could be covered by a Bubble of One provision, as listed below.

   a. Workers defined as "critical workers" under the Test for Return scheme and who are a close contact of COVID-19 cases; OR

   b. All workers who are close contacts (i.e. the critical workers criterion would not apply);

8. As with Test to Return, businesses' Health and Safety obligations would remain in force, which means that workers who use the Bubble of One approach inappropriately may be in breach of these obligations.

Timing and implementation

9. A Bubble of One provision would come into effect when the country goes to phase 2 of our Omicron strategy.

10. A decision has yet to be made about how to implement the provision. One option is to incorporate it in the Test for Work scheme.

Document 4

Recommendations

We recommend you:

a) **Note** that the Bubble of One concept refers to a person's ability to undertake work without being in close physical proximity to any other person when at their place of work;

b) **Indicate your preference for one of the following options** for categories of vaccinated, asymptomatic worker who meet a "working in isolation" criterion who could be covered by a Bubble of One provision:

i. Workers defined as "critical workers" under the Test for Return scheme and who are a close contact of COVID-19 cases; OR **Yes/No**

ii. All workers who are close contacts; OR **Yes/No**

iii. No change to current section 70 isolation requirements (i.e., no change from the status quo). **Yes/No**

c) **Consult with your colleagues** on a preferred option for categories of vaccinated, asymptomatic worker who meet a "working in isolation" criterion who could be covered by a Bubble of One provision **Yes/No**

Dr Ashley Bloomfield
Director-General of Health
Date: 4 February 2022

Hon Chris Hipkins
Minister for COVID-19 Response
Date: 8/2/2022

Bubble-of-One

If the employee is vaccinated, does **not have any symptoms** (**asymptomatic**) and is **able** to maintain an individual '**Bubble-of-One**' while at work, indoors or outdoors, then they can **return to work** when they are a close contact. They are not required to use rapid antigen testing (RATs) as part of this.

What is a Bubble-of-One?

- You are working in a bubble of one if you are undertaking your work in an indoor or outdoor space, where there are no others present in that space[1].
- If there is more than one space in any premises, there must be systems and processes in operation to ensure, so far as is reasonably practicable, that you do not intermingle at a distance closer than 2 metres with other persons using, entering, or leaving the premises.
- You **must** travel solo, to, from and around work or between jobs. This means you can't use public transport.

What do they need to do while at work?

- Strict use of a medical mask, donned before entry to the workplace, changed as needed during the day and complying with any infection prevention and control protocols at work.
- The worker must eat alone in a well-ventilated space, outdoors where possible
- The worker should use a dedicated bathroom. If this is not possible no others should be present in the bathroom.
- If symptoms develop at any stage, follow the public advice for close contacts with symptoms www.health.govt.nz/COVID-19-contact
- Continue regular workplace surveillance testing if this is already in place

What do they do when not at work?

- The employee must self-isolate at home as per standard close, including testing if applicable
- Current requirements are available at www.health.govt.nz/COVID-19-contact

[1] For definition of defined space, see: COVID-19 Public Health Response (Protection Framework) Order 2021 (SL 2021/386) (as at 23 January 2022) 9 Meaning of defined space – New Zealand Legislation [note this can be carried over to the legal mechanisms to give effect to this scheme, or slightly adapted if necessary]

Document 5

Memorandum

Identification and management of close contacts in the event of a COVID-19 exposure in the House of Representatives

Date due to MO:	7 February 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220166
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
Chrystal O'Connor	Group Manager Contact Tracing, COVID-19 Health System Response	S9(2)(a)
Dr Niki Stefanogiannis	Deputy Director Public Health, Office of the Director of Public Health	S9(2)(a)

Action for Private Secretaries

N/A

Date dispatched to MO:

Document 5

MINISTRY OF HEALTH
MANATŪ HAUORA

Identification and management of close contacts in the event of a COVID-19 exposure in the House of Representatives

Purpose

1. This memo responds to your request for advice on how close contacts would be identified and managed should a member of the House of Parliament be identified as a case and have been present in the Chamber while infectious.

2. It explains the identification of close contacts, taking into consideration the distance between cases and contacts, the nature of activities taking place at the venue, the impact of mask wearing and how this risk assessment is applied to indoor settings.

3. It also outlines the subsequent management plan for close contacts and how this alters across Phases One, Two and Three of our Omicron response.

Background

4. Aotearoa New Zealand has three phases to our Omicron strategy. Whilst the identification of close contacts does not change across the phases, the management does.

5. Workplaces need to have a clear understanding of how contacts are identified and managed, both to be able to plan for staff absences as well as to ensure adequate risk mitigation plans are in place.

Close contact identification

Definition of a close contact

6. The way we identify close contacts, and the public health definition of a close contact (refer Appendix 1) will remain the same across all three phases of the Omicron response.

7. Which close contacts are legally required to isolate, as per a Section 70 of the Health Act 1956, will change across Phase Two and Phase Three. In Phase Three, only household members of a case will be legally required to self-isolate.

8. The simplified close contact definition to inform public facing communications is as follows:

You are a Close Contact if:

You live with (are a household member of) someone who has COVID-19

OR

You had direct contact with respiratory secretions or saliva from someone who has COVID-19 (e.g., kissing, shared a cigarette, vape or drink bottle, or if the person coughed or sneezed directly on you)

OR

You have had frequent or prolonged indoor interactions with someone who has COVID-19, including sexual partners, overnight guests, shared living spaces, shared custody arrangements.

You would also be a Close Contact if:

- You were close (within 1.5 metres) to someone who has COVID-19 for more than 15 minutes AND that person was not wearing a mask or wasn't wearing it properly

OR

- You spent time in an indoor space for more than 1 hour with someone who has COVID-19 **AND** one of the following applied:
    - that person was singing, shouting, smoking, vaping, exercising, or dancing
    - that person was not wearing a mask or wasn't wearing it properly
    - the indoor space was poorly ventilated (i.e., there were no windows or doors open)
    - the indoor space was smaller than 100m^2, or about 3 double garages.

Isolation requirements for close contacts

9. The current isolation requirements for close contacts across the different phases are summarised in the table below:

	Phase 1	Phase 2	Phase 3
Close Contacts: people who work with or have been in the same place at the same time as someone infectious with COVID-19 (excluding household members of a case, who are required to self-isolate during all phases)	Isolate/quarantine, either at home or in a managed facility, **for 10 days from last exposure** Test immediately, and on day 5 and on day 8 after last exposure If COVID-19 symptoms develop during isolation, get an additional test immediately	Isolate at home, **for 7 days from last exposure** Test on day 5 after last exposure If COVID-19 symptoms develop during isolation, get an additional test immediately	**Not required to self-isolate** Self-monitor for COVID-19 symptoms for 10 days If COVID-19 symptoms develop, get tested and stay at home until negative test result is received

10. As we progress through the phases, the Section 70 order will be updated to reflect the changing advice around which close contacts are required to isolate.

11. In Phase Two, if an employee in a critical industry is identified as a critical worker, they may be able to continue to attend work throughout their isolation period, by utilising the Test-to-Return protocol for close contacts which is currently under development.

Close contacts in workplaces

12. The National Investigation and Tracing Centre (NITC) has produced a 'toolkit' [link to guidance page] to provide guidance for workplaces who have had an employee who is a case, who was at work while infectious. This guidance is available on the Ministry's website and is regularly updated to ensure it remains aligned with current public health advice.

13. The toolkit includes a contact risk assessment and categorisation table (refer Appendix 2) to give a greater understanding of which other employees (or visitors) in their workplace would be close contacts, based on proximity, time, activity and mask wearing protocols, as well as considering the size of the space and the ventilation.

Close contacts in the Chamber of the House of Representatives

14. If a Member of Parliament is identified as having been at work while infectious, Regional Public Health (RPH) in Wellington will provide advice to Parliamentary Services on how to manage the workplace exposure.

15. If a case was identified as having been in the Chamber while infectious, the public health unit would consider the size of the room and the ventilation, the number of people who were in attendance at the same time, how far apart the seats are, whether the case was wearing a mask and whether the case was speaking or not, to provide accurate public health advice regarding any potential risk from the exposure.

16. An example of how this risk assessment may be applied in the Chamber is:

    A case is identified as having been infectious in the Chamber for more than 2 hours. The case was wearing a mask the whole time and had no public speaking role during this time. All other Members were sitting or standing a minimum of 1.5m away from the case. Whilst the exact size of the Chamber is not known to Ministry staff, it is likely that in this scenario no other attendees would be considered close contacts. The public health advice would be to monitor for symptoms and get a test should symptoms develop.

17. Conversely, the scenario could be:

    A case is identified as having been infectious in the Chamber for more than 2 hours. The case had a 20-minute public speaking role during this time, when they did not wear a mask. Following investigation, the other Members seated immediately around the case were all deemed to be less than 1.5m away. It is likely in this scenario that those Members seated within 1.5m would be considered close contacts. Unless identified as critical, they would be asked to isolate and test according to the current protocols depending on what phase we are in. The remaining attendees in the Chamber would be unlikely to be close contacts.

Public health measures within the Chamber of the House of Representatives

18. The Ministry recommends that all public health measures are adhered to in the Chamber when the House is sitting, including staying at home if unwell, wearing of masks, attendees being fully vaccinated (and ideally boosted) and physical distancing, including in the media and public galleries.

19. The Ministry recommends Parliamentary Services use the workplace toolkit to consider all settings within the buildings, paying particular attention to critical rooms or locations, and work with RPH if required, to develop relevant plans.

20. These plans may include proactively reducing the capacity of various areas to ensure adequate physical distancing can be maintained, ensuring all staff and visitors are vaccinated and mask wearing protocols are strictly adhered to. Plans may also proactively identify critical employees to ensure that they have clear advice about what they must do if they are identified as a close contact.

Next steps

21. The Ministry recommends that Parliamentary Services work with RPH now on future planning for such an exposure.

22. Officials can provide further information about this topic at your request.

Chrystal O'Connor
Group Manager
Contact Tracing
Date: 6 February 2022

MINISTRY OF HEALTH
MANATŪ HAUORA

Appendix 1: Current definition of Close contact (health and disability sector)

Assessment of 'Close Contact' involves a public health risk assessment that considers multiple factors*, usually by a public health unit team led by a medical officer of health.

A person may be considered a Close Contact if they have exposure to the same air as a confirmed (or probable) case during the case's infectious period that is assessed as significant, without appropriate personal protective equipment (PPE). Exposure to the same air may include those in a setting immediately after the case, as well as while the case was present. Face-to-face exposure in an enclosed environment that is more than fleeting, and face-to-face contact outdoors within 2 metres for more than 15 minutes, will usually be considered Close Contact.

In addition, any person with the following exposure will usually be considered a Close Contact:

- direct contact with the bodily fluids or the laboratory specimens of a case
- living in the same household or household-like setting (e.g., shared section of in a hostel) with a case
- having been seated on an aircraft within 2 metres of a case (for economy class this would mean 2 seats in any direction including seats across the aisle, other classes would require further assessment)
- aircraft crew exposed to a case (a risk assessment conducted by the public health unit in collaboration with the airline is required to identify which crew should be managed as Close Contacts).

*Factors that contribute to the public health risk assessment of the level of exposure include (but are not limited to) those related to:

- setting: duration, proximity, ventilation (e.g., indoor/outdoor, ventilation system, airflow), crowding/ability to physical distance, length of time, type of activity (e.g. eating/drinking, singing, shouting, talking, exercising)
- case: infectiousness, level of symptoms, face coverings, hand hygiene, age (e.g., child vs adult)
- contact: mitigating features (all wearing face coverings correctly, using hand sanitiser, vaccination status)

Appendix 2: Assessment of contacts in a workplace

	Close range contact ≤ 1.5m of case			**Higher risk indoor contact >1.5m away from case & no close-range contact**			**Low risk contact no close-range contact or higher risk indoor contact**			
Type of interaction	Direct contact with respiratory secretions or saliva (indoors or outdoors), **OR** Face to face contact with a case who is forcefully expelling air/secretions **FOR ANY DURATION OF TIME REGARDLESS OF MASK USE**	Indoor face to face contact for more than **15 minutes**	Non face to face contact for more than **1 hour** in an indoor space	Indoor settings without good airflow or ventilation[1]: • a small space (< 100m²) for **more than 15 minutes, OR** • a medium sized space (100-300m²) for **more than 1 hour**	Indoor settings where high transmission behaviours occur • e.g., singing, shouting, smoking or vaping, playing wind/brass instruments, dancing, exertion	Indoor settings where mask use is not required, or masks are unlikely to be used	Large indoor venues (bigger than 300m²) **FOR ANY DURATION OF TIME**	Smaller indoor venues (less than 300m²) with good airflow or ventilation[1] for up to **2 hours**	Brief indoor contact within 1.5 metres of a case	Outdoor settings **FOR ANY DURATION OF TIME**
Case wore mask[2]	Close	Casual if < 2 hours Close if > 2 hours	Casual if < 2 hours Close if > 2 hours	Casual if < 2 hours Close if > 2 hours	Casual if < 2 hours Close if > 2 hours	Close	Casual	Casual	Casual	Casual
Case did NOT wear mask	Close	Close	Close	Close	Close	Close	Casual	Casual	Casual	Casual
Examples	• Kissing, spitting, hongi, sharing cigarettes or vapes, sharing drinks or utensils • Singing, shouting, coughing, sneezing • Contact sports (heavy breathing related to exertion)	• Having a conversation • Sitting across a table from someone	• Sitting within 1.5m of someone but not having a conversation	• Small offices, sick bays, toilet blocks • Close contact businesses such hairdressers or beauty salon • Buses, trains, taxis, shared work vehicles/trucks • Restaurants, cafes, bars • Medium offices	• Bars and pubs • Social gatherings • Indoor, high intensity sports • Gyms and indoor recreation settings • Faith-based sessions such as churches or mosques	• Indoor eating places such as cafés and restaurants or staff cafeterias	• School and community halls, exhibition centres, hardware stores, supermarkets	• Well ventilated classrooms/offices, Supermarkets, hardware stores • Meeting rooms, offices	• Passing each other in the corridor • Sharing an elevator • Collecting takeaways, click & collect services	• Most outdoor recreation activities, including outdoor dining • Non-contact outdoor sports • Petrol station forecourts

[1] Good air flow and ventilation is required to prevent virus particles accumulating in an indoor space. Good ventilation/airflow can be achieved by keeping windows open.

[2] For all contacts in an indoor space, mask use is only considered to be protective for up to 2 hours.

Document 6

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Retail sales of rapid antigen tests to individual members of the public

Date due to MO:	18 February 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220236
To:	Hon Chris Hipkins, Minister for the COVID-19 Response		
Copy to:	Hon Andrew Little, Minister of Health Hon Ayesha Verrall, Associate Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
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Darryl Carpenter	Group Manager, Testing and Supply	S9(2)(a)

Minister's office to complete:

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

Comment:

Document 6

Retail sales of rapid antigen tests

Security level:	IN CONFIDENCE	**Date:**	17 February 2022
To:	Hon Chris Hipkins, Minister of COVID-19 Response		

Purpose of report

1. This report responds to your request for advice on the retail sales of rapid antigen tests (RATs) to individual members of the public.

2. This report discloses all relevant information / and implications.

Background / context

1. In a briefing to Minister Verrall on 5 November 2021, the Ministry outlined its revised position on RAT as a screening tool and advised that the Ministry was proceeding with a phased roll out of RATs, including community use of authorised RATs (from February 2022) (HR20222410 refers). The roll out was planned as part of the Ministry's response to the Delta variant of COVID-19. In addition to the public health response, businesses were able to purchase RATs for surveillance testing of their workforce for health and safety purposes. This briefing is about retail sales to individual members of the public.

2. On 21 January the Ministry provided an outline of a new testing plan to support Phases Two and Three of the COVID-19 Omicron Response Plan, incorporating the use of rapid antigen tests (RATs) in parallel with the current Polymerase Chain Reaction (PCR) testing (HR20220034 refers).

3. In that briefing, the Ministry noted that the retail sales of RATs to individual members of the public was not recommended for authorisation at that time, given the risk that it could consume supplies at a time when these were globally constrained and were vital to the public health response outlined in the Ministry's Omicron testing plan.

4. The COVID-19 Public Health Response (Point-of-care Tests) Order 2021 (the POCT Order) prohibits the importation, supply, manufacture and/or use of COVID-19 point-of-care tests, including rapid antigen tests, unless authorised by the Director-General of Health. The intent of the Order is to prevent testing for COVID-19 using unverified or unaccredited methods or tools and prevent the misinterpretation of any results.

5. Currently the retail sale of RATs to individual members of the public is prohibited under the POCT Order and would require authorisation from the Director-General of Health to proceed.

6. The Director-General would need to be satisfied that, amongst other the things, the exemption for retail sales of RATs to individual members of the public is 'not inconsistent with the purposes of the Act [COVID-19 Public Health Response Act]' and is 'no broader than is reasonably necessary to address the matters giving rise to it'. The purpose of the Act is:

a) prevents, and limits the risk of, the outbreak or spread of COVID-19 (taking into account the infectious nature and potential for asymptomatic transmission of COVID-19); and

b) avoids, mitigates, or remedies the actual or potential adverse effects of the COVID-19 outbreak (whether direct or indirect); and

c) is co-ordinated, orderly, and proportionate; and
(ca) allows social, economic, and other factors to be taken into account where it is relevant to do so; and
(cb) is economically sustainable and allows for the recovery of MIQF costs; and

d) has enforceable measures, in addition to the relevant voluntary measures and public health and other guidance that also support that response.

Role that retail sale of RATs to individual members of the public could play in preventing/limiting risk of spread

7. The Ministry has developed a testing plan for the three phases of the Omicron Response Plan. The purpose of testing in Phases Two and Three transitions away from case finding and elimination, to keeping critical services and supply chains moving, and supporting those in our community most at risk from the effects of COVID-19. At phases two and three there is much greater use of RATs, supporting the Close Contact Exemption Scheme (CCES) from phase two and for testing symptomatic individuals in phase three.

8. There may be symptomatic or asymptomatic members of the public who may wish to self-test to ensure they are not infectious prior to visiting or living with a vulnerable family member (e.g., immunocompromised).

9. Authorising retail sales of RATs to individual members of the public would support greater self-management by New Zealanders during Omicron. This would potentially free up the public health response to focus publicly funded PCR and supervised RAT testing on priority populations and critical services while providing individual members of the public with access to RATs.

10. Permitting retail sales of RATs to individual members of the public could create equity issues, although these are partially mitigated by the Ministry's approach to supporting priority populations (refer paragraphs 22 to 24 below).

Current PCR capacity

11. As Omicron case numbers in the community rise, the pressure on PCR testing capacity is increasing as well as public expectations in relation to access to RATs. On 16 February 2022, PCR testing numbers were 32,285. On 11 February, baseline testing capacity with pooling was 57,384. This baseline capacity includes the use of pooling, which goes down as positivity rates increase. The baseline capacity without pooling was 29,000 unpooled. PCR testing is approaching maximum national capacity and has already started to exceed maximum capacity in some regions, including Auckland, Waikato and Bay of Plenty.

Current RATs supply

12. With the Ministry now having 7.3 million RATs in the system (as of 16 February) and forward orders of 182.5 million, we are less concerned with the impact that retail sale of RATs will have on supporting the public health response to Omicron. The Ministry is now

confident that there is sufficient uninterruptable supply of RATs for the funded Omicron testing plan.

13. Allowing the public to purchase approved RATs through retail channels would enable choice and access by the general public and small business to use RATs whilst supporting the omicron testing plan.

Regulation of RATs

14. If retail sales of RATs to individual members of the public are authorised in Aotearoa New Zealand, regulatory oversight would include:

    a) the POCT Order to authorise which tests can be imported, sold and used in New Zealand

    b) the suite of legislation that regulates the retail market in New Zealand.

    c) ongoing post market monitoring of performance and suitability of approved devices for use.

POCT Order process for authorising the retail sale of RATs

15. The Director-General of Health has authorised a range of organisations to import, supply, distribute or sell to other authorised persons, *excluding the importation or supply for any individual's use*. Therefore, the retail sale of RATs to individual members of the public will need to be authorised by the Director-General of Health under the Order before it can proceed. The retail sale of RATs is likely to meet the conditions for an exemption under the POCT Order, which are that it meets the purposes of the COVID-19 Public Health Response Act and is 'no broader than is reasonably necessary to address the matters giving rise to it'.

16. The Ministry would continue to authorise which tests can be imported, sold or used in New Zealand. If retail sales were authorised by the Director-General of Health, only authorised RATs could be sold in New Zealand.

17. As at 16 February 2022, 11 RAT devices have been authorised under the POCT Order. The Ministry has a process in place for evaluating the quality and reliability of new point-of-care tests, including RATs. The Ministry's technical evaluation framework has recently been revised in light of Omicron and a review of the data. The revised evaluation framework will potentially allow more innovative testing solutions that could improve New Zealand's COVID-19 Response. To support this, the Ministry will also provide clarification on the criteria and rationale for approving RATs, along with education to the public and business on the use (and misuse of RATs) that have been approved.

18. New Zealand Customs (Customs) monitor and enforce the importation of RATs under the POCT Order to ensure that only devices that are authorised under the Order are allowed into the country. Customs view is that authorising the sale of authorised RATs to the individual members of the public would not have any negative operational implications for Customs and may reduce their enforcement workload.

19. The Ministry of Health is responsible for enforcing the POCT Order once RATs are in the country. This includes the sale and use of unauthorised RATs within the country.

20. The monitoring and enforcement of the POCT Order is currently complaints-based. The Ministry would continue to use this approach to enforcement if retail sales to individual members of the public is authorised. The risks associated with the use of unauthorised RATs for this group is low, given that self-isolation requirements for close contacts and other public health measures will continue to apply.

Commerce Commission

21. Retail sales of RATs to individual members of the public would be regulated under the Commerce Act 1986, the Fair Trading Act 1986 and the Consumer Guarantees Act 1993.

22. S9(2)(g)(i), S9(2)(h)

Australian response to price gouging

23. In Australia, RAT testing is free for people who are suspected to have COVID-19 or who are close contacts.

24. The Australian Competition and Consumer Commission has received a high number of consumer reports about pricing and selling practices relating to rapid antigen tests. The most significant issues raised by consumers are excessive pricing, false and misleading claims, refusal to provide receipts and package splitting. Several matters have been referred to other appropriate regulators (Police and Therapeutic Goods Administration).

25. The Australian Government introduced temporary measures under their Biosecurity Act 2015 to prohibit price gouging and impose restrictions on the improper export of RATs, effective for the period 8 January to 17 February 2022.

How New Zealand has monitored price gouging during the pandemic

26. In New Zealand suppliers can charge what they want but it is illegal under the Fair Trading Act 1986 to lie about the reasons for the price they charge.

27. Issues around price gouging have emerged during the pandemic in relation to products such as face masks and hand sanitisers at times of high demand. At no point has New Zealand introduced any regulatory change in response to this behaviour.

28. The Ministry for Business, Innovation and Employment (MBIE) set up a website (Price Watch) where consumers can record price gouging and this website is still active and monitored by MBIE.

29. If the retail sale of RATs is authorised then consumers would be able to notify concerns via the Price Watch website and this would be monitored and followed up by MBIE.

30. While New Zealand has imported or has on order a large supply of RATs which are also available to businesses and will be available for the private market, there are still global supply constraints which may encourage price gouging and panic buying. If the retail sale of RATs is authorised, MBIE, the Ministry of Health and the Commerce Commission will need to monitor the situation to assess whether further regulation is needed.

Equity

31. COVID-19 has disproportionately affected Māori and Pacific Peoples and people in socioeconomic deprived areas.

32. If an exemption is made to allow the retail sales of RATs to individual members of the public, we would need to closely monitor the impact that allowing private purchase of RATs would have on equity and protection of Māori, Pacific, disabled and other priority populations and critical health services. Making RATs available to those who can afford them in an environment of increasing global shortage of RATs will impact on equity if other mitigations are not in place.

33. This will be partly mitigated, however, by the Ministry having secured supplies of RATs for the public health response. The Ministry has pre-loaded community providers who work with priority populations with supplies of RATs, and it will continue to support those providers with supply, logistics, training, and advice in the supply and use of RATs.

Next steps

25. If there is 'in principle' support from Ministers for the retail sale of RATs, the next steps are:

    a) The Director-General of Health would authorise this use under the POCT Order, subject to the Director-General being satisfied that the requirements in the Order have been met; and if authorisation is given:

        i. notifying the wholesale and retail sector of the decision
        ii. update sector and delivery partners
        iii. update the regulatory sector and the approach to managing complaints
        iv. developing public communications on the decision
        v. develop guidance and update existing guidance
        vi. ongoing monitoring of equity of access to RATs.

26. The Ministry is recommending that retail sales of RATs to individual members of the public does not begin until at least early March 2022. This will allow time for the private sector to secure sufficient supplies of RATs, which is likely to reduce the risk of price gouging and panic buying.

Recommendations

We recommend you:

a) **Agree** in principle the sale of authorised point-of-care rapid antigen tests to individual members of the public in New Zealand

b) **Note** that the retail sale of authorised point-of-care rapid antigen tests (RATs) to individual members of the public is currently prohibited under the COVID-19 Health System Response (Point-of-care Test) Order 2021 (POCT Order)

c) **Note** that if you give 'in principle' agreement for the sale of authorised RATs to individual members of the public, as the Director-General of Health I would need to be satisfied that the requirements in the POCT Order have been met and then authorise this as an exemption to the POCT Order

d) **Note** that subject to the Director-General of Health's authorisation, the next steps would be to notify the wholesale and retail private sectors, update sector delivery partners and the regulatory sector, update our approach to managing complaints, and then communicate the decision to the wider public

e) **Note** that if Ministers provide 'in principle' approval, implementation will not start until at-least early-March 2022, to ensure sufficient supplies of RATs are available within New Zealand for the private sector.

f) **Note** the Ministry will monitor equity of access to RATs.

Dr Ashley Bloomfield
Director-General of Health
Date: 18 February 2022

Hon Chris Hipkins
Minister for the COVID-19 Response
Date:

Document 7

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Processing of requests under the Official Information Act 1982 and learnings from the Pfizer information release incident

Date due to MO:	15 February 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220182
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
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Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Document 7

Processing of requests under the Official Information Act 1982 and learnings from the Pfizer information release incident

Security level:	IN CONFIDENCE	**Date:**	09 February 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose

1. This report provides an overview of the Ministry of Health's final processing of requests under the Official Information Act 1982 (the Act) and identifies improvements to the Ministry of Health's processes relating to the finalisation of material for release from your office.

2. This follows the inadvertent release of information following an administrative error.

Background

3. On 2 February 2022, Newsroom published information relating to the purchasing price of COVID-19 vaccinations, which was inadvertently released in a response to a request for information received by your office. The response was prepared by the Ministry and released by your office on 25 January 2022.

4. Given the nature of the information, this error had the potential for causing reputational damage internationally for the Crown and a loss of confidence from vaccine suppliers.

5. The Ministry apologises for the error and has reviewed its procedures for preparing information for your office and reviewed this incident to identify improvements to prevent such an error from reoccurring.

6. In identifying best practice, the Ministry has considered the approaches taken by other agencies. Additionally, as part of a review already underway by an external consultant, the Ministry is seeking input specifically in relation to this situation.

Process and incident

7. The Ministry of Health has continuously improved its processing of replies for requests for information under the Act in response to the significant growth in the number of requests. The number of requests for information responded to by the Ministry has tripled over the last two years.

8. In line with convention, the Ministry provides you with draft replies to requests for information made under the Act.

9. The incident occurred at points where the Ministry sent your office the final response to be sent to the requester, following feedback from your office, and where the final response was despatched.

10. When the electronic file was emailed to your office by the Ministry it was labelled as the final document. Unfortunately, the information was not correctly prepared by the Ministry and the error was not identified by your office prior to being sent. Although documents were marked to be withheld, those same documents were also (incorrectly) marked with the "Released under the Official Information Act" watermark.

Process

11. For ease of reviewing material for release/to be withheld, it has been established with the Ministers' offices that *all* information in scope of a response is provided in one document bundle, including information recommended to be withheld in full.

12. Once reviewed, any amendments are advised to the Ministry by your office and the Ministry is directed to prepare the final version of documents for release. Where documents are withheld in full, requesters are advised of this in the response letter.

13. The process for the provision of the final material from the Ministry to the office has changed frequently on direction from the office. Copies of documents to be withheld in full may, or may not, be included when the Ministry sends the final bundle of documents to the office.

14. In this instance, the Ministry intended to remove the documents to be withheld in full prior to sending the final bundle to the office.

15. The advantage of removing the information is that it reduces the number of fully redacted pages in a response.

Incident

16. At the point the final bundle of information was provided to your office the documents were listed as withheld in full in the response letter. The action of removing the documents from the bundle did not occur at the Ministry prior to despatch.

17. Redactions to documents released in part were applied. The Official Information Act 1982 red watermark was applied to all documents. This application of the watermark on the withheld pages meant it would not have been immediately obvious that the pages should have been removed.

18. A final check of the documentation was not carried out by your office prior to sending the response. Given the different approaches adopted by the office regarding how the final information is provided to it, the Ministry could have been clearer in advising the office about the format of this response to avoid any doubt or confusion.

Identified Improvements

19. The Ministry has immediately standardised its process for providing information for final response to your office and fully documented the revised processes. Any alternative action will be by exception only.

20. The improvement is that all documents to be withheld in full will be fully redacted in the bundle.

21. We recommend that your office completes a final quality check by checking the information for release against the signed response letter.

Other agencies

22. During the period July to December 2021, the Ministry of Health provided replies to more than 2,800 requests for information. There is no comparative agency when considering volume and nature of requests for information. For example, for the same period the Ministry of Justice provided replies to fewer than 500 requests for information. However, to identify process improvements, the Ministry consulted with other relevant agencies on the how material is provided to Ministers' offices for final replies.

23. The approaches used by agencies vary including how and when final versions are provided to ministerial offices. Notably, whether documents are provided individually or in one bundle, and whether documents are provided in a redacted form or not.

24. Additionally, in 2021 following an inadvertent release of Budget material in May 2021, the Public Service Commission reviewed the Ministry's processes for releasing information and found that there the Ministry has sufficient mitigations in place. The Commission noted that a new document management tool would be an improvement. The Ministry is in the process of acquiring a new workflow tool that will assist with this functionality. It is anticipated that this will be fully functioning by July 2022.

Independent advice

25. An external consultant is reviewing the processes underpinning the Ministry of Health's ministerial servicing. The Ministry has asked them to urgently provide additional specific advice on how it releases information with particular regard to this incident.

Stakeholders in this release of information

26. The Ministry has been in contact with pharmaceutical companies, including Pfizer following the inadvertent release of information.

27. The Ministry has provided redacted versions of the documents to each of the suppliers and communicated the cause of the incident and steps taken to prevent future occurrences.

28. The Ministry understands that you met with Pfizer on 4 February 2022 to convey an apology and explanation of what occurred.

s 9(2)(g)(i) [redacted]

Equity

30. The proposal in this paper does not impact equity. Replies to requests for information are sent in a format suitable for the recipient of the information, including being provided in an accessible format.

Next steps

s 9(2)(g)(i) [redacted]

32. Your office will be advised of any relevant further improvements identified by the independent review of the Ministry's ministerial servicing.

Recommendations

We recommend you:

a) **Note** that the Ministry has now adopted a standardised process for providing information to your office to respond to requests for information **Yes/No**

b) **Note** that the Ministry will work with your office to develop a safeguard checklist for sending replies to official information act responses **Yes/No**

c) **Note** that the Ministry continues to liaise with pharmaceutical companies regarding the inadvertent release of information **Yes/No**

d) **Release** this briefing proactively with minor redactions. **Yes/No**

Dr Ashley Bloomfield
Te Tumu Whakarae mō te Hauora
Director-General of Health
Date: 17 February 2022

Hon Chris Hipkins
Minister for COIVD-19 Response
Date: 21/02/2022

ENDS.

Document 8

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Shifting to Phase Three of the Omicron response strategy

Date due to MO:	22 February 2022	**Action required by:**	23 February 2022
Security level:	IN CONFIDENCE	**Health Report number:**	HR20220302
To:	Hon Chris Hipkins, Minister for COVID-19 Response		
Copy to:	Rt Hon Jacinda Ardern, Prime Minister Hon Andrew Little, Minister of Health Hon Ayesha Verrall, Associate Minister for COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
Ashley Bloomfield	Director-General of Health	S9(2)(a)
Caroline Flora	Acting Deputy Director-General, System Strategy and Policy	S9(2)(a)

Minister's office to complete:

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

Comment:

Document 8

Shifting to Phase Three of the Omicron response strategy

Security level:	IN CONFIDENCE	**Date:**	21 February 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose of report

1. This report provides a minor update to earlier Ministry of Health advice (HR20220289) on shifting from Phase Two to Phase Three of the Omicron response strategy. This report proposes a new start date for the move to Phase Three: 11.59pm on Thursday 24 February 2022 instead of Wednesday 23 February.

Summary

2. There is now significant growth in cases of COVID-19 in the community, particularly in Auckland but with sustained outbreaks in other centres and cases are now doubling every 3 days. If this continues, there will be more than 5,000 cases per day by Thursday 24 February 2022.

3. The growth in case rates, test positivity rates and rising demand for timely reporting of testing is putting significant pressure on many parts of the health system, especially lab capacity for processing Polymerase Chain Reaction (PCR) tests. This has led to some operational shifts in Auckland and Waikato to Phase Three measures already, where legal changes were not required.

4. At a Public Health Risk Assessment on 21 February 2022, the Ministry of Health assessed whether to shift to Phase Three measures, based on three pre-agreed critical indicators:

   a. rate of growth in cases,

   b. contact tracing and case management capacity, and

   c. testing demand and capacity.

   An assessment of operational readiness to shift to Phase Three was also undertaken.

5. Based on the public health assessment and data in relation to the indicators above, I recommend moving to Phase Three of the Omicron Response Strategy at 11:59pm on Thursday 24 February 2022.

6. This report updates an earlier report (HR20220289) which proposed moving to Phase Three at 11.59pm on Wednesday 23 February 2022. That report noted that the proposed timing was contingent on advice from Parliamentary Council Office on drafting timelines to underpin the move to Phase Three. The revised date (23 February 2022) reflects an allowance for that drafting time.

Document 8

Recommendations

We recommend you:

a)	**Note** that COVID-19 cases numbers are currently doubling every next three days, meaning we will likely reach 5000 daily cases by Thursday 24 February 2022.	**Noted**
b)	**Note** that the Ministry of Health has undertaken a Public Health Risk Assessment of whether to shift from Phase Two to Three of the Omicron response strategy.	**Noted**
c)	**Note** the Ministry of Health's view that the conditions have been met to justify a shift to Phase Three shortly, based on a public health assessment against pre-agreed critical indicators.	**Noted**
d)	**Note** that some elements of Phase Three (where legal changes were not required) have already been operationalised in Auckland and Waikato, as they were considered necessary to ensure effective delivery of services, such as timely testing results and rolling out RATs more widely for certain uses.	**Noted**
e)	**Note** the assessment of health system readiness to move to Phase Three at **Appendix Two**.	**Noted**
f)	**Agree** to move from Phase Two to Three of the Omicron response strategy at 11.59pm on Thursday 24 February 2022.	**Yes** / **No**
g)	**Note** that work is underway to update clinical guidance for managing particularly vulnerable groups given that a strong focus on further strengthening clinical and welfare support for these groups is a key focus for Phase Three.	**Noted**
h)	**Note** that work is underway to advise you on the proportionality of certain border settings, particularly the requirements for self-isolation, if the government agrees to move to Phase Three in its domestic public health settings.	**Noted**

Dr Ashley Bloomfield
Te Tumu Whakaere mō te Hauora
Director-General of Health
Date: 22 February 2022

Hon Chris Hipkins
Minister for COVID-19 Response
Date: 22/2/2022

Shifting to Phase Three of the Omicron response strategy

Background

7. On 26 January 2022, the Government announced a three-phase Omicron response strategy. The three phases are intended to provide an agile and sustainable response given the significantly greater transmissibility of Omicron and the need to manage widespread cases of COVID-19 in the community.

8. We note that shift between Omicron response phases is not the same as a change of COVID-19 Protection Framework colour settings. Phase shifts are primarily about deploying health and welfare resources to manage the impacts of COVID-19 as effectively, equitably and sustainably as possible.

Public health advice

9. On 21 February 2022, the Ministry of Health conducted a public health risk assessment to consider whether to shift from Phase Two to Three of the Omicron response. The assessment involved a comprehensive analysis and discussion of the Omicron outbreak and the three critica7l indicators for informing a potential shift from Phase Two to Three of the Omicron response strategy.

10. Based on the available information, the conditions have been met to justify a shift to Phase 3. Therefore, it is advised that New Zealand shift from Phase Two to Phase Three of the Omicron response on 11:59pm on Thursday 24 February 2022.

11. Some elements of Phase Three (where legal changes were not required) have already, and will continue to be, operationalised ahead of the timeline set out this report. These changes were considered necessary to ensure effective delivery of services, such as timely test result reporting and rolling out the use of RATs more widely.

Phase Three purpose and measures

12. The shift to Phase Three involves fewer changes to public health settings and systems than the shift from Phase One to Two. This is because many of the public health changes and systems, such as beginning to make RAT tests available and digital self-management, were stood up in Phase Two and are simply being expanded in Phase Three.

13. Key changes under Phase Three include:

    a. close contacts other than household contacts, will no longer be required to isolate,

    b. there will be much less individual case management (e.g. such resources will be reserved for highly vulnerable people), and

    c. RATs will also be used for diagnostic purposes to help preserve laboratory PCR testing capacity.

14. Under Phase Three, the intent is that resources and effort (particularly relating to testing, case investigation and contact tracing) will be targeted much more on populations at

risk of severe outcomes from COVID-19. The corollary is relying on most of the population to manage their own symptoms, undertake contact tracing through self-management digital platforms, test themselves and isolate at home as appropriate.

15. The detailed features of Phase Three are outlined in the **Appendix One**.

Critical indicators for shifting to Phase Three

16. On 21 February 2022 (prior to the assessment), I agreed to three critical indicators provided by the Director of Public Health, to inform a potential shift from Phase Two to Three. These are set out in Table 1 below.

Table 1: Three critical indicator for shifting from Phase Two to Phase Three

Indicator	Example of metrics	Rationale
1. Rate of growth in cases	Case numbers, stratification by demographics and consideration of these trends against short term forecasting.	Identified trends in overall cases growth, and growth within high-risk populations and high-risk locations.
2. Contact tracing and case managem ent capacity	Not achieving target time from case notification to interview – targets: 80% within 24 hours for non-text notified, 80% within 36 hours for Māori, Pasifika or dep 9-10, and 48 hours for other groups.	Indicates national, PHU and primary care capacity to manage high-risk cases and contacts.
3. Testing demand	Current and predicted laboratory capacity, turnaround times, availability of testing apparatus and reagents.	Indicates the demands for laboratory PCR testing for diagnosis and capacity limits, and the need to move to other diagnostic tools.

Indicator one: Rate of growth in cases

17. Over the past week, up to and including 20 February 2022, there have been 10,924 cases reported. As of 18 February 2022, the effective reproduction rate is estimated to be 1.8 (up from 1.4 on 14 February) and the doubling time is estimated to be 3.3 days. (down from 7.6 on 14 February).

18. Overall case rates from 07 February 2022 to 12 February 2022 were 51.8 per 100,000. By contrast, from 13 February 2022 to 18 February 2022, case rates had risen steeply to 156.3 cases per 100,000. This is a 300 percent increase compared to the previous 6 days.

Indicator two: Contact tracing and case management capacity

19. With the number of cases growing rapidly, there is a subsequent increase in demand for contact tracing and case management services. This growth rate is outstripping contact tracing and case management capacity, leading to delays. This growth adds to the existing number of people requiring management and support, placing an additional burden on the health system.

20. The National Case Investigation Service (NCIS) was designed to manage up to 1000 cases per day. Over the period of 19-20 February, 4547 cases were reported and the NCIS managed 92% of these. The service involves ensuring that case is first informed that they are positive (if we know that they have not received the automated text message) and then undertaking the case investigation.

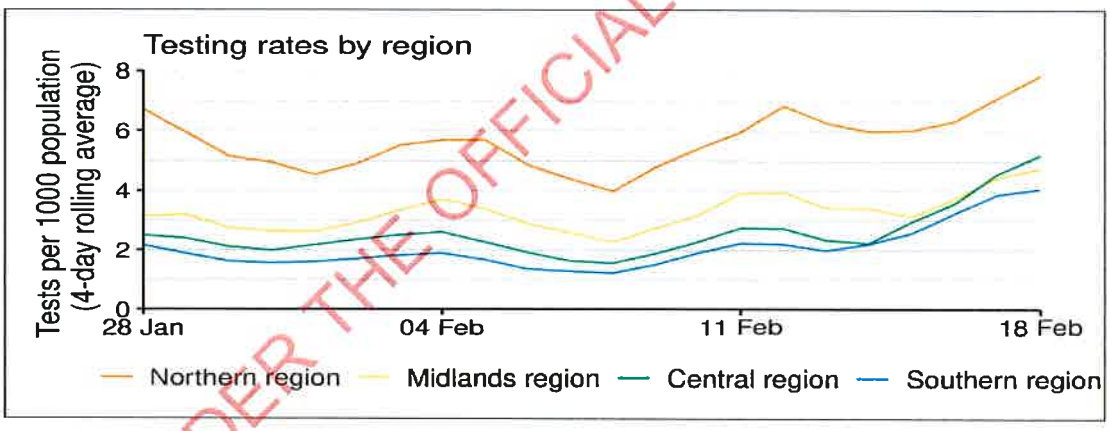
21. As at 21 February, there is a backlog of 290 lists needing uploading under exposure event management, this includes 243 schools containing an average of 50 contacts per list. This equates to 12,150 contacts not yet in the system. There were over 9000 exposure events identified in the past 7 days, with approximately 24,000 contacts in the system.

22. A shift to Phase Three allows cases to identify and notify contacts themselves through the use of digital tools and reduces the need for case-management of people who are not considered vulnerable to severe outcomes from COVID-19. This shift also removes the need to identify contacts outside of households, meaning less societal impact for both individuals and businesses/schools.

Indicator three: Testing demand

23. The growth in cases, resulting in an increase in those currently defined as close contacts has put significant strain on New Zealand's PCR testing, especially in the areas most affected such as the Auckland Metro area – see Figure 1 testing rate by region.

Figure 1 – Testing rate by region (four day rolling average) by region and DHB, 22 January to 12 February 2022



24. As at 21 February, there are 60,000 PCR test samples awaiting processing in the network with most of them already being near the 48-hour mark. Testing facilities have typically aimed to have 80% of tests returned within 24-hours. Demand for PCR testing has now surpassed the daily capacity limit for un-pooled testing, significantly impacting on timeliness of processing: as at 20 February 2022, consequently only 29% of tests were processed within the 24-hour KPI.

25. The Ministry has already begun to introduce a range of operational changes within the parameters of the existing laws around testing to ensure that the health system is able to cope given the rapid escalation in demand for testing. These changes include:

    a. Using RATs instead of PCR testing for border testing, as already permitted under the Required Testing Order,

b. Providing additional communications publicly, further clarifying and emphasising who should and should not seek a test (this has already begun to reduce demand), and

c. Moving to RATs for people who have been to Locations of interest or are contacts rather than cases.

26. These changes effectively move us closer to Phase Three already and are consistent with the broader case of the need to move there imminently.

Sufficient supply of RATs

27. We note that there is currently sufficient supply of RATs available to move to Phase Three with an estimated 7 million currently available in the system and large deliveries arriving from Wednesday this week. While initial stocks appear sufficient in the short term, it will remain important to continue to monitor the rate of RAT use to ensure supply continues to be sufficient over the coming weeks.

28. Work is underway to update clinical guidance for vulnerable groups, to assist with among other things the use and distribution of RATs. This aligns with the strong focus on further strengthening clinical and welfare support for these groups is a key focus for Phase Three.

Readiness to shift to Phase Three

29. The Ministry has undertaken an assessment of readiness to shift to Phase Three set out at **Appendix Two**. The assessment covered operational readiness to shift in areas such as testing, Healthline, contact tracing, care in the community, digital enablers, and communications.

30. The assessment has determined that the system will need until Friday 25 February 2022 to be operationally ready to shift to Phase Three.

Legal mechanisms

31. For the shift to Phase Three to take place, a series of legal changes need to be made to the relevant Orders and section 70 notices.

Border settings

32. On 1 February 2022, Cabinet noted advice from the Ministry of Health that international arrivals are considered similar in COVID-19 risk profile to close contacts in the community and should be required to meet broadly similar testing and isolation requirements to close contacts of domestic cases [CAB-22-MIN-0008 refers].

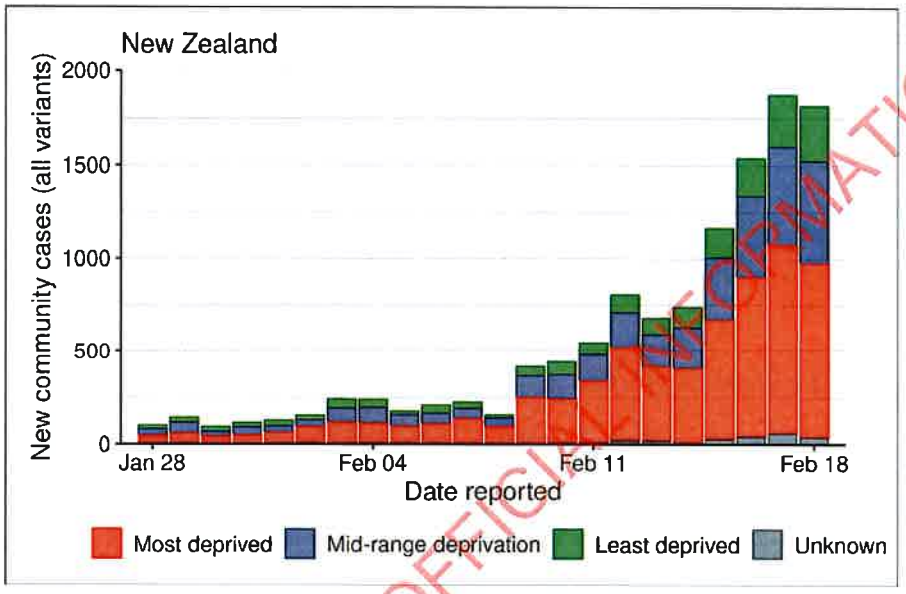
33. The shift to Phase Three measures will have implications on the legitimacy of our current border settings and self-isolation settings proposed under Reconnecting New Zealanders.

34. With the relative risk at the border diminishing as the rate of domestic transmission increases it is unlikely that all MIQ or self-isolation settings will remain proportionate and justifiable. The Department of Prime Minister and Cabinet is preparing advice on this matter, which will include public health advice, legal and operational implications. This is expected to be provided to you later this week.

Equity

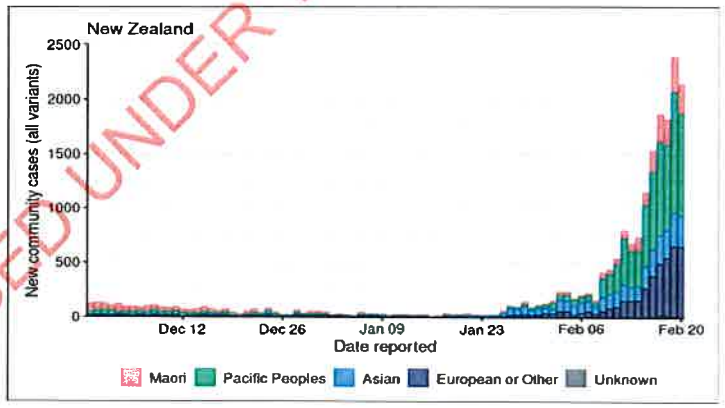
35. The regional distribution of the cases across New Zealand continues to be uneven, with 81% of cases currently in the Auckland Metro DHBs and Waikato DHB. Furthermore, some groups of the community continue to experience an inequitably high degree of the disease burden from COVID-19. For example, the disease burden correlates closely with large populations living in areas of high deprivation and suffering from housing disadvantage. Figure 2 below highlights that the burden has been felt increasingly by people from mid to high levels of deprivation over time and this is likely to continue unless countervailing measures are put in place.

Figure 2 – Community cases by deprivation level



36. Figure 3 below similarly highlights that there is a disproportionate burden of disease from COVID-19 falling on both Māori and Pacific peoples compared with other groups.

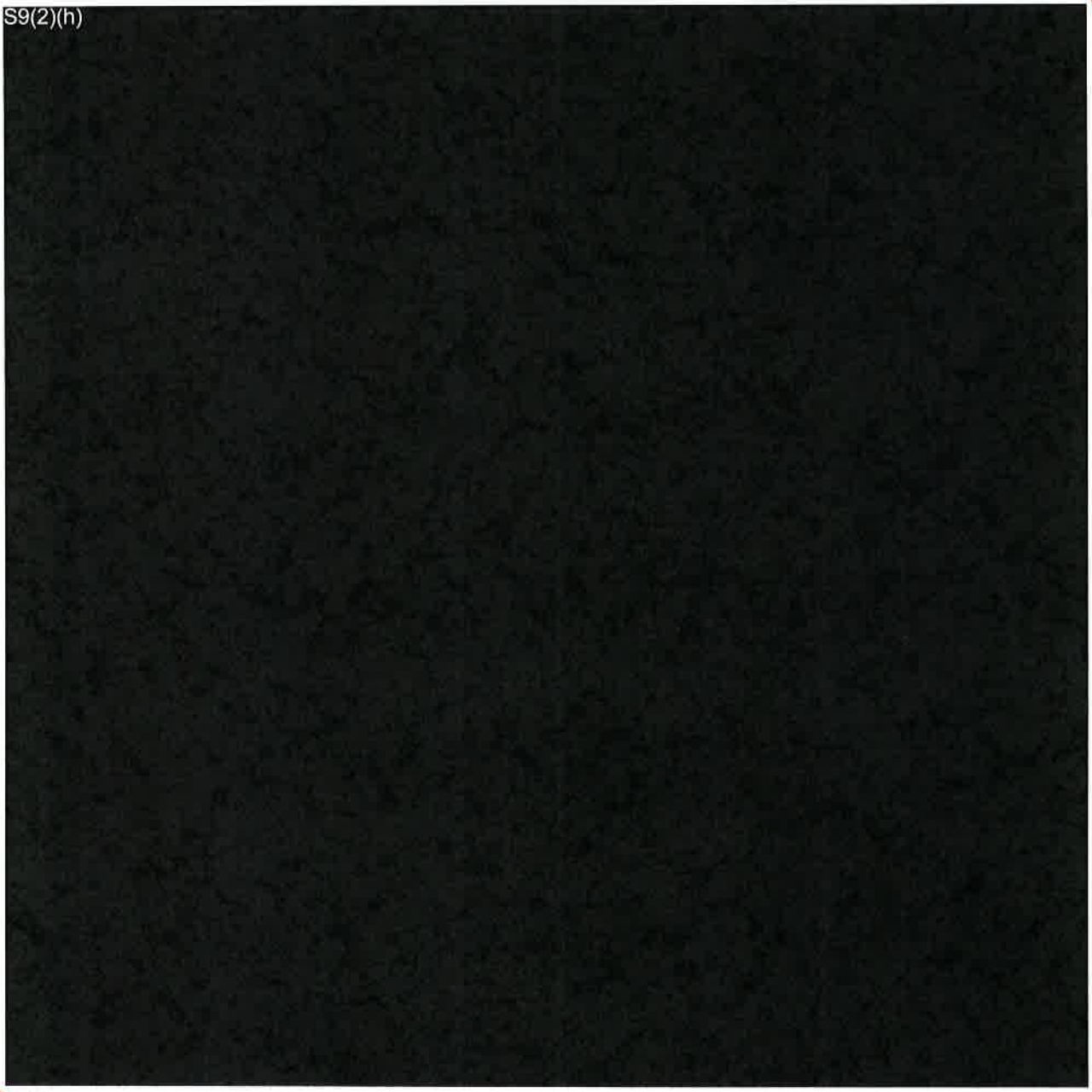
Figure 3 – Community cases by ethnicity



37. Phase Three, like Phase Two, has been designed to explicitly help address the inequities above by prioritising access to health system resources for those most at risk. A shift to Phase Three is intended to prioritise those with the greatest health and welfare needs, and those most at risk from poor outcomes due to COVID-19.

38. As noted above, Māori and Pasifika are significantly more likely to be disproportionately represented in these groups and to suffer disproportionately from a widespread outbreak. Addressing this situation is critical for the government's COVID-19 strategy to be both effective and equitable. This is why community-based protections for the groups most likely to be impacted (such as Pasifika, who comprise more than half the cases in the last week) remain critical to the effectiveness of the Omicron response strategy overall and Phase 3 in particular.

S9(2)(h)



Next steps

43. We propose you agree to share this advice with Ministers and other agency colleagues. We note that DPMC are also preparing a briefing on system-wide readiness for moving to Phase Three and the appropriate timing given those broader considerations.

ENDS.

Appendix One: Features of Phase Three

Testing	• Focus PCR testing on priority populations • Most symptomatic testing changes from PCR to RATs • No need to confirm RAT test with PCR unless advised • Supervised RAT testing available from participating pharmacies, GPs and community providers • RATs available for pick up from collection sites, which may include participating CTCs, GPs and pharmacies • RAT testing for border workers • Continue Close Contact Exemption Scheme • RATs become diagnostic
Case investigation and contact tracing	• Cases identified via positive PCR, RATS or symptoms • Notified by text and directed to online self-investigation tool • Contact tracing limited to those who have not completed the self-investigation tool and are Maori, Pacific and/or High Deprivation (9-10). • Self-investigation tool to focus on very high-risk contacts e.g., correctional facilities households and Aged Care facilities • PHUs focus on very high-risk settings • Limited use of LOIs, push notifications and Bluetooth • No case investigations
Isolation and quarantine	• Cases isolate for 10 days • Household close contacts isolate for the same time period as the case, and test when symptomatic or on day 3 and 8 of isolation • Close contacts not required to isolate
Care in the community	• Majority of positive cases self-managed • Clinical care and wraparound health and welfare support focused on those with high needs • Support for positive cases to isolate at home • Lower risk people present directly through other channels

Appendix Two: Health system changes required to move to Phase 3

In the following table, the changes described will be ready end of 24 February 2022, unless specified otherwise

Element	What needs to change to support a shift to Phase Three
Healthline	Update scripts and FAQs: • change of phase relies on automation in NCTS and BCMS continuing to operationalise and remaining critical issues from deployments over the last fortnight being closed out • public adoption of self-management tools is still being operationalise, and the public are reaching out for support via Healthline at volumes higher than expected. Improvements need to be prioritised alongside public communication being simplified • final policy settings being available to support the development of scripts and change for frontline staff as soon as possible • pathways to advise people on where their tests results are (including advising they are positive) need to be streamlined as multiple sources are providing this information without the necessary clinical support.
DHB readiness	Update range of operational guidance (testing and supply)
Testing	PCR testing for border workers to RATs. RATs collection sites established a MIQFs. Being implemented for ports and airports Still working on an agreement with GPs to clarify what RAT distribution they will do (ready by COB Thu 24/2) – led by Testing Team
	Most symptomatic testing changes from PCRs to RATs. Participating GPs, pharmacies and community health providers have been preloaded with RATs. There are currently 57 collection sites nationwide and more will be opened as volume increases to support RAT testing once phase 3 commencement date agreed. DHBs and collection sites have been preloaded for this purpose
	Supervised RAT testing available from GPs and community providers
	RATs available for pick up from collection sites, CTCs and GPs
Case investigation and contact tracing	Cases notified by text and directed to online self-investigation tool Digital infrastructure set up to be rolled out to large portion of the population
	Self-investigation tool to focus on very high-risk contacts. We will still be advising cases and household contacts to isolate (not actively managing them). The s.70 will be clear they still have to isolate. They will be texted to notify of this. Work is underway on reporting of those in self-management pathways (linked to the digital tool). High risk populations identified and strategy to target these people established.

Document 8

Element	What needs to change to support a shift to Phase Three
	This involves phoning people who don't access via digital channels (mostly about avoiding digital exclusion). It involves a non-digital way to inform people they are a case and directing them to where they can get support/assistance/advice.
Care in the community	Coordinated public communications that support safe self-management. No major changes involved; just more cases to manage.
Digital pathways and enablers	Enhancement to assisted channel automating communication of negative result Digital infrastructure in development and production commencing Tuesday-Thursday
	Enhancement to RAT recorder to enable reporting of RAT distribution by CTCs
	Enhancement with HealthLink to enable GPs to record supervised RAT result
	Integration of systems to support positive cases (as part of self tests (RAT collection model)
Other assisted channels	Update scripts for assisted channels Update community provider and GP testing locations
Communications	Update range of public facing testing collateral Update key messages and webpages (UAC and MoH) Update HealthPoint - community provider and GP testing locations, RAT pick up locations Considerable work involved to update key communication messaging and tailor to different audiences
Border settings	a. Review of self-isolation settings for travellers under step 1 of RNZ b. Review of self-isolation settings for all other travellers c. Move returnee testing to RAT to align with traveller self-isolation settings d. Align close contact management with contract tracing settings This will have implications for both the isolation requirements under the ABO and MBO to ensure proportionality between isolation requirements in NZ and those arriving from overseas.

Document 9

Briefing

Further information on the retail sale of rapid antigen tests

Date due to MO:	23 February 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220310
To:	Hon Chris Hipkins, Minister for COVID-19 Response		
Copy to:	Hon Andrew Little, Minister of Health Hon Ayesha Verrall, Associate Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Bridget White	Deputy Chief Executive, COVID-19 Health System Response	S9(2)(a)
Jo Pugh	Acting General Manager, COVID-19 Testing and Supply	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Document 9

Further information on the retail sale of rapid antigen tests

Security level:	IN CONFIDENCE	**Date:**	23 February 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose of report

1. Further to the advice provided HR20220236 *Retail sales of rapid antigen tests*, this briefing provides additional information on the retail sale of rapid antigen tests (RATs).

2. This report discloses all relevant information.

Background / context

3. On 18 February the Ministry provided you with advice on the retail sale of RATs to individual members of the public. You agreed in principle to the sale of authorised point-of-care rapid antigen test to individual members of the pubic in New Zealand.

4. In that report I advised that the retail sale of authorised point-of-care rapid antigen tests (RATs) to individual members of the public was currently prohibited under the COVID-19 Health System Response (Point-of-care Test) Order 2021 (POCT Order)

5. The Ministry advised that subject to your in-principle agreement, as the Director-General of Health I would need to be satisfied that the requirements of the COVID-19 Health System Response (Point-of-care Test) Order 2021 (POCT Order) have been met and then authorise this as an exemption under the POCT Order and then gazette my authorisation.

6. On Monday 21 February I considered whether the 11 RAT devices authorised under the POCT Order should be fully exempted from the prohibitions on import, manufacture, sale, and distribution under the POCT Order and approved the full exemption of the 11 tests.

7. The exemption continues to control which specific point-of-care tests, including RATs, are able to be to used, sold, manufactured, imported and packed. However, it enables full public access to, and use of, the specified tests without restriction.

8. The Ministry intends to gazette the exemption and provide supporting information on the Ministry website on Thursday 24 February 2022.

Ministry Supply

9. The Ministry has ordered, as of 22 February, 182 million RATs with delivery from February to June 2022. Of these 82 million have been confirmed for delivery and the other 100 million are not yet confirmed. The Ministry has established distribution channels to support the

CCES (see appendix two) and is currently finalising the distribution channels for symptomatic testing for phase three.

10. The other 100 million RATs on order have not yet had delivery schedules confirmed. These orders include 19.5 million ordered for delivery in the week of 20 March, 13.6 million for the week of 27 March and 41.8 million ordered for delivery in April.

11. Of the 182 million tests ordered, 8 million are supervised tests and the other 174 million are unsupervised tests, meaning they can be used for self-testing.

12. A modelling scenario based on a peak of 25,000 new cases per day occurring on 31 March suggests that a cumulative total of almost 45 million RATs will be used by the end of April. This would consume more than half of the 84 million RATs that have been confirmed for delivery by the end of April. In a situation in which demand for RATs is twice this level or disruption to global supply chains means that the supplies received are half or less of the orders confirmed, domestic supply of RATs could be constrained.

13. In a situation in which the available supply of RATs is constrained and may not fully meet the level of demand, there will be a need to prioritise the allocation of supply.

14. At this stage, the Ministry will not be on-selling its supply of RATs to the private market as it needs to prioritise its supply for the public health response. ✓

15. The Ministry is developing a policy for prioritising the Ministry's supply of RATs, which it expects to finalise this week. The focus will be on prioritising testing of symptomatic individuals, protecting people at greater risk of serious illness from COVID-19, and critical workers to enable critical services to continue to operate. The policy will inform decisions about distribution of RATs in scenarios where either supply or distribution networks are constrained.

Equity Issues

16. The principles and policy for prioritising the supply of RATs will help support equitable health outcomes by testing to ensure those most at risk of poor health outcomes from the Omicron variant get an early response to their health and support needs.

17. Distribution channels have been set up with DHBs and a range of community providers to ensure that priority populations can get RATs when they need them. The Ministry is in the process of contracting with community providers (Māori, Pacific, disability and others) who have expressed an interest in providing supervised RATs to the people/communities who receive their services.

18. Many community providers have been preloaded with supplies of RATs along with training and resources, so they are ready to use when they need too. The Minister is proactively participating in provider forums to provide support where needed.

Pricing of RATs

19. This advice is supplementary to the information provided in the earlier briefing on the retail sale of RATs (HR20220236).

Legislation is in place to address price gouging

20. Under normal competitive conditions, an increase in the price of a good or service is a signal to the market to either reduce demand or increase supply by either by incumbent firms or new entrants.

21. It is not illegal for businesses to increase their prices, however the Fair Trading Act 1986 prohibits misleading and deceptive conduct and false representations. This means that if a business gives a reason for a price increase it must be true, otherwise the business risks breaching the Fair Trading Act and people can submit complaints to the Commerce Commission.

Additional legislative mechanism that could be used

22. S9(2)(h) [redacted]

23. Ministers instead agreed to set up Price Watch www.pricewatch.govt.nz. Price Watch has been relatively successful in gathering information about market conduct and MBIE have contacted retailers directly where there are concerns and referred to the Commerce Commission if it involves misleading and deceptive conduct.

24. Some private measures have been taken by retailers, for example, Trademe has removed traders on their site who re-sell at excessive prices, including the re-sale of hand sanitiser at excessive prices during the first lockdown.

Engagement with retailers

25. Communication and engagement with key stakeholders on the retail supply of rapid antigen tests will be undertaken through MBIE's established channels, including the Biz.govt website and sector newsletters, following confirmation of details of the retail scheme. MBIE is working closely with Health and other government agencies to align this content with Phase 3 of the Omicron Response Plan. A closed briefing for stakeholders is also suggested.

Next steps

26. The Ministry will:

    a. publish the signed gazette notice fully exempting the 11 authorised RAT devices from the prohibitions on import, manufacture, sale, and distribution under the POCT Order on Thursday 24 February 2022 to align with the public announcement to move to Phase Three of the Omicron Response Plan.

    b. publish supporting information relating to the gazette notice on the Ministry website at the same time.

27. MBIE will engage with key stakeholders on the retail sale of rapid antigen tests through its established channels following the announcement to move to Phase Three.

Document 9

Recommendations

We recommend you:

a) **Note** that the Ministry will submit the gazette notice fully exempting the 11 authorised RAT devices from the prohibitions on import, manufacture, sale, and distribution under the POCT Order 2021 to align with the public announcement to move to Phase Three of the Omicron Response Plan

b) **Note** that information will be published on the Ministry of Health website to align with the public announcement to move to Phase Three of the Omicron Response Plan

c) **Note** that MBIE will engage with key stakeholders on the retail sale of RATs through its established channels and is working closely with the Ministry of Health to align the content of its communication.

Dr Ashley Bloomfield
Director-General of Health
Te Tumu Whakarae mō e Haoura
Date: 23 / 02 / 2022

Hon Chris Hipkins
Ministry for COVID-19 Response
Date: 24/2/2022

ENDS.

Document 10

Briefing

Reconnecting New Zealanders: Monitoring, compliance and enforcement of self-administered tests

Date due to MO:	23 February 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220279
To:	Hon Chris Hipkins, Minister for COVID-19 Response		
Copy to:	Hon Andrew Little, Minister of Health Hon Dr Ayesha Verrall, Associate Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Bridget White	Deputy Chief Executive	S9(2)(a)
Jo Pugh	Acting General Manager, Testing and Supply	S9(2)(a)

Minister's office to complete:

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

Comment:

Document 10

Reconnecting New Zealanders: Monitoring, compliance and enforcement of self-administered tests

Security level:	IN CONFIDENCE	23 February 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response	

Purpose of report

1. This briefing provides advice on the monitoring, compliance and enforcement of unsupervised self-administered rapid antigen tests by travellers arriving in New Zealand as part of the Reconnecting New Zealanders' programme.

Recommendations

2. We recommend you:

a) **Note** that the testing and reporting requirements for travellers entering New Zealand under the Reconnecting New Zealanders programme involve a high-trust, low-touch approach and require travellers to 'do the right thing'.

b) **Note** that rates of non-compliance with testing and reporting requirements could be an issue that will need to be managed carefully by the Ministry to ensure that non-compliance is seen as unacceptable by returning travellers.

c) **Note** that the Ministry will report on compliance weekly, as part of the Reconnecting New Zealanders reporting, beginning from next week.

d) **Indicate** whether you wish to discuss any aspects of this briefing. **Yes/No**

Bridget White
Deputy Chief Executive
COVID-19 Health System Response
Date: 23/02/22

Hon Chris Hipkins
Minister for COVID-19 Response
Date:

Document 10

Monitoring, compliance and enforcement of self-administered tests under Reconnecting New Zealand

Background / context

Testing plan updated to support COVID-19 Omicron Strategy

1. On 20 December 2021, Cabinet agreed in principle to defer Step 1 of the phased reopening of the international border, Reconnecting New Zealand, until late February 2022 in response to the emergence of Omicron [CAB 21-MIN-0558].

2. On 1 February 2022, Cabinet agreed to the dates for the five steps of Reconnecting New Zealand. Step 1 commences at 11:59pm Sunday 27 February and allows New Zealand citizens travelling from Australia to enter New Zealand via the medium-risk pathway. The final step will open the medium-risk pathway from October 2022 to all visa categories [CAB-22-MIN-0008 refers].

3. Cabinet also agreed to change the medium-risk pathway settings to include:

   a. a day 0/1 self-administered RAT test

   b. a day 5/6 self-administered RAT test.

4. The management of arrivals entering the self-isolation pathway will be broadly aligned (but not identical) to those for close contacts of cases in the community, given the similar level of risk that both groups pose, i.e. a **high-trust low-touch** approach. There are some differences, for example, arrivals who test positive or return an indeterminate result after a day 0/1 or 5/6 rapid antigen test (RAT) will be required to take a follow-up PCR at a Community Testing Centre or healthcare provider.

5. As part of these changes, returnees will be required to report their day 0/1 and day 5/6 test results, whether they are negative, indeterminate, or positive.

Monitoring of and compliance with self-administered RATs

6. Travellers undertaking and reporting the results of unsupervised self-administered tests, places the responsibility on travellers to 'do the right thing' and relies on a high-level of voluntary compliance.

7. Steps taken to encourage high levels of voluntary compliance includes:

   a. *Awareness.* Communications/information outlining requirements and expectations (including pre-departure testing (PDT) arrangements and requirements) available via the Unite Against COVID-19 website

b. *Convenience*. Issuing of welcome packs, including RATs (complete with instructions) and guidance material outlining travellers' obligations, to all travellers in advance and on arrival at airports
c. *Airport Based Support*. Health presence at the airports to answer any questions related to testing and self-isolation
d. *Reminders*. Time-bound electronic prompts to travellers while in self-isolation to report on their test results
e. *Continued Remote Support*. Access to 0800 number(s) should self-isolating returnees have any questions around testing requirements and processes.

8. The monitoring of voluntary compliance will be facilitated through reconciliation of self-reported RAT test results against travellers' details. Should arrivals fail to comply there will be an escalating response to further encourage compliance (in line with the VADE model: voluntary, assisted, directed and enforced). This will include:

a. *Assisted*. Reminder text prompts, follow-up email, phone call
b. *Directed*. Issuance of a directive letter
c. *Enforcement*. If non-compliance continues unabated, an infringement letter will be issued.

See Appendix 1 for the Compliance, Monitoring and Enforcement process overview.

9. The Ministry anticipates:

a. Relatively high levels of voluntary compliance in the 'early days' of the international border reopening.
b. As the number of travellers entering New Zealand increases s 9(2)(g)(i) [redacted] the Ministry expects an associated increase in levels of traveller ambivalence in reporting test results.

10. The rate of non-compliance is difficult to estimate at this stage but it could potentially be quite high. What is important is that the Ministry moves quickly on monitoring, compliance and enforcement activity to stem any public perception that non-compliance is acceptable. Public confidence that returning travellers are doing the right thing is critical.

11. The team in place to support monitoring and compliance will be resourced in a [redacted] to cope with any non-compliance as the traveller volumes increase. [redacted] infringement notices will be issued rapidly with follow up action for infringement [redacted] others and to further encourage voluntary [redacted] will also be supported by ongoing communications [redacted] travellers to voluntarily comply.

12 Regular reporting on traveller testing compliance, including detail on infringement notices, will be prepared by the Ministry weekly and incorporated into Reconnecting New Zealanders reporting from next week on.

Equity

13. Every inbound traveller has access to the Welcome Pack including the RAT kits required for testing.

14. An information sheet is inserted in the Welcome Packs issued at the airports for those travellers with English as a second language. This information sheet directs travellers to guidance material online that is translated into 27 different languages.

15. Those travellers that do not have access to a device or the internet will be able to submit RAT test results via an 0800 line.

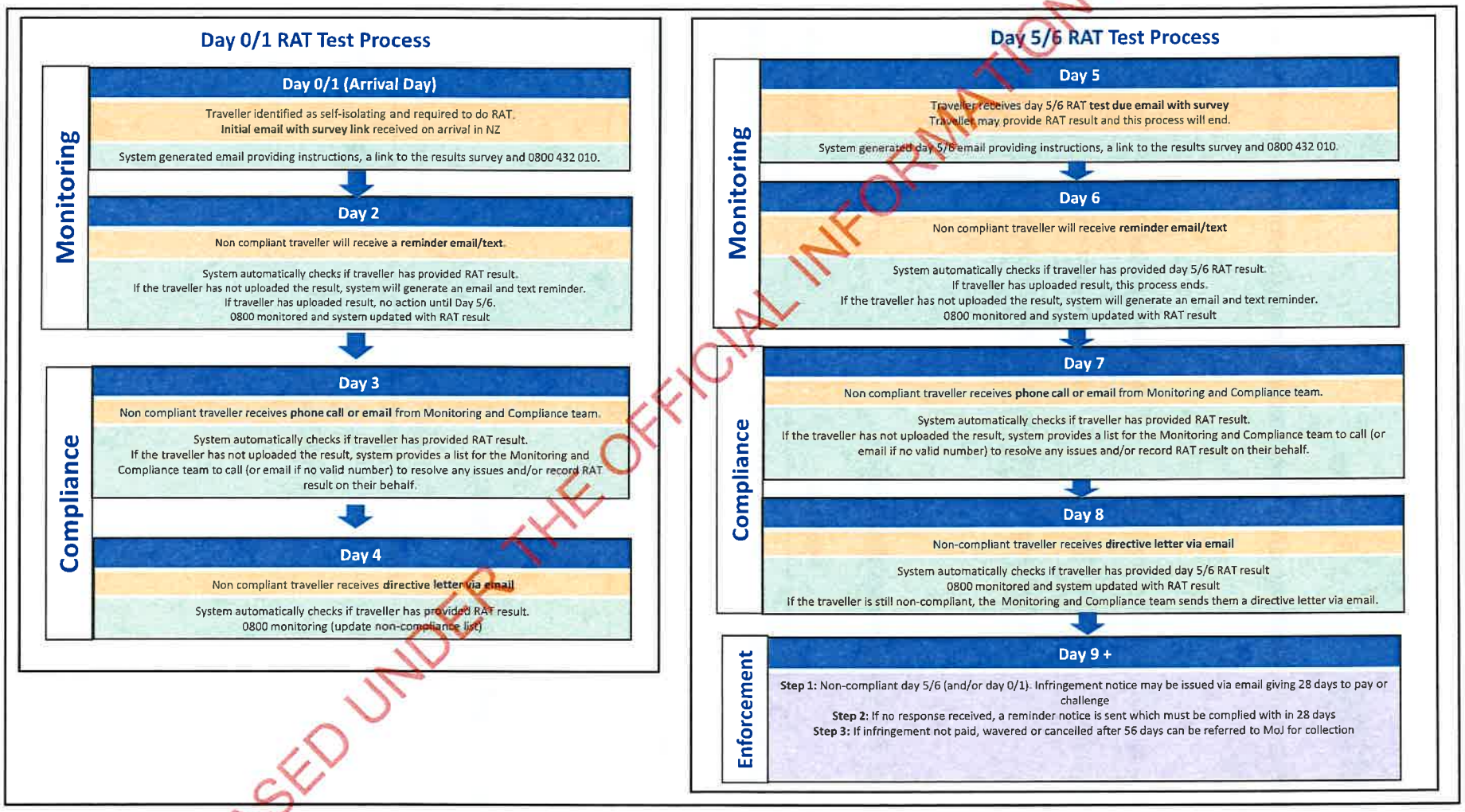
Next steps

16. From 28 February, the Ministry will closely monitor the number of travellers entering the country with the phased reopening of the international border and the numbers not adhering to their obligation to self-administer rapid antigen tests and subsequently report the results. The Ministry will look at making adjustments to resourcing of monitoring and compliance should numbers of non-compliant travellers prove higher than anticipated.

ENDS.

Document 10

APPENDIX 1: Reconnecting New Zealanders: Rapid Antigen Test monitoring, compliance and enforcement overview



Document 11

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Pre-departure testing and vaccination requirements for the no isolation pathway

Date due to MO:	23 February 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220286
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
Dr Ashley Bloomfield	Te Tumu Whakarae mō te Hauora Director-General of Health	S9(2)(a)
Caroline Flora	Acting Deputy Director-General, System Strategy and Policy	S9(2)(a)

Minister's office to complete:

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

Comment:

Document 11

Pre-departure testing and vaccination requirements for the no isolation pathway

Security level:	IN CONFIDENCE	**Date:**	23 February 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose of report

1. This report outlines further advice regarding:
   a. pre-departure testing (PDT) requirements and the countries from which persons will be exempted before arriving in New Zealand by air, and
   b. vaccination requirements for the no isolation pathway (Low-risk Pacific Pathway) [CAB-22-MIN-0008 refers].
2. I intend to make new Gazette notices to reflect the above in time for the commencement of Reconnecting New Zealanders with the World (RNZ) from 11:59pm on Sunday 27 February 2022.

Background

Changes to the COVID-19 Act to allow for broader sub-delegation

3. The COVID-19 Public Health Response Act 2020 (the Act) was amended in November 2021 and broadened the provision that allows for sub-delegation of power.
4. The Director-General of Health (or the Ministry of Business, Innovation and Employment chief executive if appropriate), can now make decisions related to the operation of a COVID-19 order by written notice (via a Director-General (DG) or Chief Executive notice). This might include:
   a. specifying something (e.g. which vaccines are 'COVID-19 vaccines' for the purposes of a COVID-19 order)
   b. determining something (e.g. determining when someone should take a COVID-19 test within their period of isolation)
   c. exempting something from a requirement (e.g., exempting a group of travellers from having a PDT).

5. Using a written notice to make these decisions via a DG notice provides more flexibility and agility for the COVID-19 legislative framework.[1] DG notices are drafted by the Ministry of Health (the Ministry), require my approval, and must be published on the New Zealand Gazette website.

Reconnecting New Zealanders to the World

6. The new COVID-19 Public Health Response (Air Border) Order (the Order) and several associated Gazette notices are intended to simplify the legislative framework to support RNZ by creating three pathways for arrivals to New Zealand which result in either:
   a. no isolation or quarantine requirements upon arrival (the no isolation pathway)
   b. self-isolation requirements upon arrival (the self-isolation pathway)
   c. managed isolation and quarantine (MIQ) upon arrival (the MIQ pathway).
7. Some specific details to give effect to RNZ are specified by DG notice to ensure that they can easily be changed as settings change. This includes the testing regime in self-isolation, vaccination requirements for the different pathways, and PDT requirements.

Gazette notice – countries that are exempt from COVID-19 pre-departure testing requirements

8. From 11:59pm on Sunday 27 February 2022, new PDT requirements will allow travellers entering New Zealand via the self-isolation or managed isolation and quarantine pathways to choose either:
   a. a PCR completed 48 hours prior to departure, or
   b. a supervised Rapid Antigen Test (RAT) or a supervised loop-mediated isothermal amplification (LAMP) test completed 24 hours prior to departure.
9. All eligible travellers entering via jurisdictions on the no isolation pathway will continue to be exempt from this requirement and will not require a PDT.
10. Currently, 105 jurisdictions are exempt from PDT requirements because travellers cannot access a PCR test within 48 hours but can access a RAT/LAMP tests within 24 hours. An additional 21 jurisdictions are exempted as they do not have sufficient testing capacity or there is no public health rationale due to there being no COVID-19 in that jurisdiction (e.g. the Ross Dependency in Antarctica) [*Gazette* notice number 2022-go126 refers].
11. A new DG notice is required to support these changes to reflect the new RNZ pathways.

Six jurisdictions will be exempt from new PDT requirements

12. Following review by the Ministry, the new DG notice will exempt travellers departing six jurisdictions from the new PDT requirements because they cannot meet the requirements or there is no public health rationale. These jurisdictions are the Federated

[1] A DG notice is secondary legislation for the purposes of the Legislation Act 2019. This means that it must be published in accordance with the relevant requirements in the Legislation Act (i.e., in the Gazette as soon as practicable after it is made); it must be presented to the House of Representatives; it is a disallowable instrument (which means that the House of Representatives may 'disallow' them, like any other regulation)

State of Micronesia, Fiji, Kiribati, the Republic of the Marshall Islands, the Solomon Island, and Tonga.

13. Travellers departing the eight Pacific jurisdictions on the no isolation pathway (American Samoa, the Cook Islands, Nauru, Niue, Samoa, Tokelau, Tuvalu, and Vanuatu) and Antarctica are not subject to the new PDT requirements in the Order and do not need to be included in this new DG notice.[2]

14. Further explanation of the rationale for the revised list is provided at **Appendix One**.

15. The new list of jurisdictions exempted from PDT was informed by updated advice from the Ministry of Foreign Affairs and Trade (MFAT). That advice outlined access and capacity for travellers to meet the new PDT requirements. However, it is important to note that as with previous assessment there are limitations due to:

    a. there being no agreed definition for determining "feasibility" (assessment is based on anecdotal and the best available evidence in country)

    b. PDT turnaround times, no matter the testing mode, are affected by domestic outbreaks in (i.e. if there is strain on testing capacity) which can quickly change reducing the ability to maintaining a live list

    c. the variation within a jurisdiction (tests may be accessible in some areas in the required timeframe and not in others).

16. Noting the above, there may be a need for the Ministry to review the list of exempted jurisdictions if MFAT becomes aware of issues of testing availability or capacity in non-exempted jurisdictions.

Gazette notice – COVID-19 vaccination requirements for the no isolation pathway

17. The objective of vaccination requirements is to keep as much risk offshore, and to minimise the spread of COVID-19 in the community by ensuring arrivals are protected against severe disease to the greatest extent possible.

18. Vaccination reduces the strain on the health system in the context of wide community transmission. Additionally, it provides personal protection against severe disease not only while in New Zealand but also upon their return to the Pacific. It also contributes to the overall promotion of vaccination as a key tool in reducing the spread and burden of COVID-19 globally.

The current minimum vaccination requirements to enter New Zealand by air are intentionally broad

19. Since 1 November 2021, non-New Zealand citizens who arrive by air must meet minimum vaccination requirements prior to departure for New Zealand. Cabinet agreed this measure to provide an additional layer of protection and to reduce the risk of COVID-19 transmission to the New Zealand community.

20. Based on COVID-19 Vaccine Technical Advisory Group (CV-TAG) advice, and agreed by me the vaccination requirements are:

[2] Refer schedule 8 and schedule 11.

a. a complete primary course of vaccination with any of the 33 COVID-19 vaccines approved by at least one government or approval authority (or an approved combination of those vaccines in their origin country)

b. the last dose must be at least 14 days before departing for New Zealand.

21. There are certain groups that are exempt from this requirement, such as those aged 16 years and under, refugees, people evacuated from Afghanistan, and those who have a certificate from a health practitioner confirming they cannot be vaccinated against COVID-19 due to medical reasons. New Zealand citizens are also exempt.

22. There is also an exemptions process in place, whereby, upon application I may grant an exemption from the vaccination requirement to individuals coming from a jurisdiction where there is limited access to COVID-19 vaccines.

23. The vaccines accepted for this requirement are intentionally broad based on equity and access as most people have no choice as to which vaccine they are offered. As there may be some variability in effectiveness in vaccine types it also recognised that testing and MIQ would provide additional mitigations. The accepted vaccines for this requirement will be specified in a DG Gazette notice made under the Act.

Vaccination requirements for non-New Zealand citizens on the no isolation pathway

24. In November 2021, Cabinet noted that the same minimum vaccination requirements would also apply to non-New Zealand citizens entering New Zealand by air from no isolation pathway jurisdictions [CAB-21-MIN-0548 refers].

25. The broader list of vaccines was to make it easier for these travellers to comply with this requirement. The start of RNZ and creation of the self-isolation pathway, has provided an opportunity to reassess the vaccination requirements for the no isolation pathway.

26. I believe it is reasonable to align the vaccination requirements for the no isolation pathway with those of the self-isolation pathway. This will also align with the specified requirements to be considered vaccinated against COVID-19, which is also used for My Vaccine Pass eligibility and mandatory vaccination requirements for some workers.

The new vaccination requirements will be the same as the self-isolation pathway which are narrower

27. Requiring all travellers entering New Zealand via the self-isolation pathway to meet the definition of fully vaccinated is more restrictive to provide additional protection. The requirements are either:

a. a full course or a combination, of any of the 10 Medsafe or World Health Organization Emergency Use Listing (WHO EUL) approved vaccines with the last dose at least 14 days before they depart for New Zealand, or

b. if a person has received a complete or incomplete course of a COVID-19 vaccine that is not one of the Medsafe or WHO EUL vaccines, they must receive an additional dose of one of the following vaccines at least 14 days before they depart for New Zealand: Pfizer, AstraZeneca, AstraZeneca, Janssen, or Moderna.

28. These vaccination requirements for arrivals on the no isolation pathway will apply only to non-New Zealand citizens and those who are aged 17 years and older. Upon application, I can grant an exemption from the vaccination requirement if there a person is from a

jurisdiction where there is limited access to COVID-19 vaccinations. This may be applied to countries where their vaccination programme has not yet extended to vaccinating under the age of 18 years, which is the case in Vanuatu.

29. As all countries on the no isolation pathway use at least one of the 10 WHO EUL vaccines above for their COVID-19 vaccination programmes, this change is not expected to present any additional barriers to arrivals using this pathway for entry to New Zealand.

Next steps

30. Following completion of inter-agency consultation on these notices, I will sign these notices so that they are in force by 11:59pm on Sunday 27 February 2022. These will then be published on the *New Zealand Gazette* website.

Recommendations

I recommend you:

a)	**Note** that the COVID-19 Public Health Response Act 2020 amended in November 2021 broadened the provision that allows for sub-delegation of power to the Director-General of Health (or the chief executive of the Ministry of Business, Innovation and Employment if appropriate) to make decisions related to the operation of a COVID-19 order via a Director-General or Chief Executive Gazette notice.	**Noted**
b)	**Note** that the new COVID-19 Public Health Response (Air Border) Order 2021 and several associated Gazette notices are intended to simplify the legislative framework to support Reconnecting New Zealanders to the World.	**Noted**
c)	**Note** my advice regarding pre-departure testing requirements and relevant exempted jurisdictions, and the vaccination requirements for the no isolation pathway (Low-risk Pacific Pathway) in line with the report back noted in CAB-22-MIN-0008.	**Noted**
d)	**Note** that I will soon issue Gazette notices regarding pre-departure testing exemptions and vaccinations requirements as outlined in this Health Report to support the commencement of Reconnecting New Zealanders.	**Noted**
e)	**Note** that it is intended a new COVID-19 Public Health Response (Air Border) Order 2021 and associated Gazette notices will be in force from 11:59pm on Sunday 27 February 2022.	**Noted**

Dr Ashley Bloomfield
Te Tumu Whakarae mō te Hauora
Director-General of Health
Date: 23 February 2022

Hon Chris Hipkins
Minister for COVID-19 Response
Date:

ENDS.

Document 11

Appendix One: Exemption from pre-departure testing requirements

The table below outlines further the jurisdictions that are currently exempted from New Zealand's PDT requirements and those which will continue to be in the new PDT exemption Gazette notice, based on updated MFAT advice.

Jurisdiction	*Currently Exempt*	*Remain Exempt*	*Rationale*
Afghanistan	Yes	No	While there are no direct flights from Kabul to New Zealand currently (there are no commercial flights available), PCR tests can be obtained in Kabul should flights resume. Most people MFAT is assisting depart for New Zealand from Iran and Pakistan and have been able to meet airline PDT PCR test requirements from both Pakistan (Islamabad) and Iran (Tehran and Marshad).
American Samoa	Yes	Yes	No isolation pathway/quarantine-free travel jurisdiction not subject to PDT requirements in the Order.
Antarctica	Yes	Yes	Antarctica is already exempted by the Order and does not need to be included in the DG notice. There is also no PCR testing capacity or RAT supplies in Antarctica and currently no COVID-19 in the Ross Sea Region.
Belize	Yes	No	Belize can facilitate both RAT and PCR testing for travel at various locations.
Cook Islands	Yes	Yes	No isolation pathway/quarantine-free travel jurisdiction not subject to PDT requirements in the Order.
Federated States of Micronesia (FSM)	Yes	Yes	There is no community transmission of COVID-19 currently as FSM borders are effectively closed. There is very limited health system capacity, but there is CDC-provided viral testing capability. Based on CDC and country reporting FSM have capacity to test approximately 300 cases each week. It is not currently possible for testing labs to guarantee turnaround times will be met (one day prior to departure for the United States).
Fiji	Yes	Yes	PCR and RAT access remains highly constrained and is prioritised for the most vulnerable in Fiji's health system and user pays tourists receiving their PDT at resorts. MFAT advice indicates that Fiji has run out of PCR Gen-X cartridges and has one-to-two months' supply of RATs. Restrictions on the private import and sale of RATs further compounds the issue. Based on the current numbers, New Zealand's rising infection rate is likely to overtake Fiji's falling infection rate within the next two weeks, meaning that questions around the proportionality of risk would arise from any decision to impose a PDT requirement on Fiji at this stage.
Kiribati	Yes	Yes	The capability of Ministry of Health and Medical Services (MHMS) to deliver PCR tests for outgoing travellers has improved but so has testing demand due to Kiribati's growing outbreak. There is limited (or no) availability for RATs for outgoing travellers as the limited RAT supply is focused on local surveillance testing and the in outer islands. There is no LAMP testing capability. MFAT's assessment is that a PDT requirement could be met but would want to carefully manage Kiribati's capability to do so. In addition, MFAT believes it would make the most sense for requirements for Kiribati to align with requirements for other Pacific Island jurisdictions with similar risk profiles. Maintaining Kiribati's exemption reflects this. There are currently only a small number of travellers from Kiribati to New Zealand. This could change if/when RSE resumes, and flights become more regular.

Nauru	Yes	Yes	No isolation pathway/quarantine-free travel jurisdiction not subject to PDT requirements in the Order.
New Caledonia and French Polynesia	Yes	No	Both can conduct PCR and RAT tests.
Niue	Yes	Yes	No isolation pathway/quarantine-free travel jurisdiction not subject to PDT requirements in the Order.
Palau	Yes	No	Departing Palau is only via Guam (a United States territory) or Taiwan. Both require PDT and the Government of Palau coordinates flights to align with flight schedules. Palau can turn around testing to the standard required by the US (one day prior to departure).
Republic of the Marshall Islands (RMI)	Yes	Yes	There is no community transmission of COVID-19 currently as RMI borders are effectively closed. There is very limited health system capacity, but there is CDC-provided viral testing capability. Based on CDC and country reporting RMI have capacity to test approximately 60 cases each week. It is not currently possible for testing labs to guarantee turnaround times will be met (one day prior to departure for the United States).
Samoa	Yes	Yes	No isolation pathway/quarantine-free travel jurisdiction not subject to PDT requirements in the Order.
Solomon Islands	Yes	Yes	The requirement for PCR PDT for travellers would be extremely challenging and almost certainly beyond the capability of the Solomon Islands health system to deliver given the lack of availability of tests. The system is also currently under significant stress due the current COVID outbreak. The capability is also fragile due the very small number of trained technicians in Honiara who can process the tests (five).
Tokelau	Yes	Yes	No isolation pathway/quarantine-free travel jurisdiction not subject to PDT requirements in the Order.
Tonga	Yes	Yes	Tonga is experienced with PCR testing but the lab at the main hospital (Vaiola) is very stretched currently and would struggle processing PCR tests within 48 hours for travellers. It would also be challenging for travellers to get PCR test results in time for the weekly Air NZ flight to Auckland that departs on Tuesday afternoons as services are closed on Sundays. Supervised RATs are possible but dependent on the availability of health workers to supervise.
Trinidad and Tobago	Yes	No	PCR and RAT tests both available. Testing for travel would need to be done privately as the public health centres are focused on those who are either symptomatic or are contacts of a positive case.
Turkmenistan	Yes	No	Anecdotal evidence (via limited media reporting) suggests COVID-19 testing capacity is limited, access difficult, and results unreliable (i.e. people are not told they are positive, but instead are diagnosed with pneumonia. Turkmenistan continues to report zero COVID-19 cases but imposed a strict lockdown in January suggesting it was facing a COVID-19 surge. However, MFAT advise that, Turkmenistan should no longer be exempt considering the overarching public health narrative around PDT and that it is also an outlier compared to those exempted in the Pacific and Antarctica.
Tuvalu	Yes	Yes	No isolation pathway/quarantine-free travel jurisdiction not subject to PDT requirements in the Order.
Vanuatu	Yes	Yes	No isolation pathway/quarantine-free travel jurisdiction not subject to PDT requirements in the Order.

Document 12

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Enabling COVID-19 cases who are critical workers to return to work

Date due to MO:	2 March 2022	**Action required by:**	2 March 2022
Security level:	IN CONFIDENCE	**Health Report number:**	HR 20220374
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
Dr Ashley Bloomfield	Director-General	
Stephen Glover	Group Manager COVID-19 Policy	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Document 12

Enabling COVID-19 cases who are essential workers to return to work

Security level:	IN CONFIDENCE	**Date:**	2 March 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose

1. This report seeks your agreement to instruct the Parliamentary Counsel Office (PCO) to draft an amendment to the COVID-19 Public Health Response (Self-isolation Requirements and Permitted Work) Order 2022 (SRPW). This amendment order would permit the Director-General of Health (DG) to allow COVID-19 cases to carry out work rather than self-isolate where they are critical to the operation of vital services and under specified conditions.

Background/context

Now that the SRPW has come into force, the DG may no longer create exemptions from standard requirements that household contacts and cases of COVID-19 isolate

2. The SRPW specifies requirements to isolate for COVID-19 cases and their household contacts. It also enables the Close Contact Exemption Scheme and the Bubble of One.

3. The DG was previously able to grant exemptions to the isolation requirements for cases, when these requirements were detailed in a section 70 notice. The SRPW doesn't currently have a mechanism to allow the DG to grant exemptions.

Isolation requirements are under review more broadly

4. Our core message is that people should not work (and should stay home) while they are unwell and for as long as they are unwell. The required isolation periods are intended to minimise the risks of transmission while people are, or may be, infectious.

5. The DG has asked for advice on whether the required isolation periods for cases and their household contacts can be reduced. This advice will also consider whether household contacts may break isolation, if they are asymptomatic and test negative. Advice will be provided later this week.

6. These wider changes would help to reduce pressures on the economy and society from large numbers of people being required to isolate, while there are high rates of COVID-19 in our communities.

7. However, there will be exceptional circumstances where services important to New Zealand's economy and COVID-19 response are reliant on small numbers of key workers, and where those workers may need to return to work to keep those services operating – even when they might otherwise be required to isolate as COVID-19 cases. The ability for the DG to grant specified exemptions to the requirement for cases to isolate would provide a safety net in these situations.

The ability of the DG to create exemptions from isolation provisions for cases needs to be restored urgently

8. We are aware of a number of areas where the pressures from cases isolating are threatening essential health services and critical links in supply chains. Restoring the ability for the DG to grant exemptions will provide a mechanism to respond to these issues. For example:

   - Sources in the transport sector have asked that workers in highly critical positions in lifeline services who are COVID-19 cases be permitted to return to work, under appropriate conditions. Air Traffic Controllers and Maritime pilots are examples of workers who fall into this category.
   - We have been informed that Interislander ferries may begin cancelling sailings this week because of staff shortages due to the need for cases to isolate.
   - We have recently received a request that asymptomatic health staff be allowed to work in COVID-19 wards (but only in those wards), from day 0 for as long as they remain asymptomatic.

9. Notices issued under the proposed power would focus on specific workers and would likely have specific safeguards relevant to the context of each situation, to ensure the most appropriate public health measures are in place. They would not be widely applicable like the Close Contact Exemption Scheme, which currently covers over 1 million workers (over 40% of the workforce). However, we note that issuing exemptions on a 'case-by-case' basis, as opposed to a wider exceptions approach, places an additional burden on the DG to ensure that the scope of each exemption is limited to the minimum necessary.

Discussion

10. Isolation of cases continues to be a major tool in our current system for managing COVID-19 as we move into Phase 3 of our Omicron response plan.

11. Introducing exemptions from the requirement to isolate for cases increases the risk of the transmission of COVID-19, even if an exemption is subject to stringent measures to prevent transmission. Creating exemptions could be seen as sending contradictory messages to the public.

12. On the other hand, there is a realistic possibility that reducing the isolation period for cases may be the only practicable way of ensuring that key services such as critical health services and air traffic control continue to be delivered at a necessary level.

13. On balance, we conclude that:

    a) there is a strong case for enabling the DG to create exemptions from the requirement for cases to isolate to allow certain people to return to work;

    b) the DG would need to ensure that ability to work for cases was limited to particular roles or services, where a clear need has been established;

    c) the DG would need to specify appropriate restrictions which ensure that an exemption does not undermine the use of isolation as a tool to manage the transmission of COVID-19 – including on when cases could return to work and the associated public health requirements to manage the risk of infection;

d) The terms of exemptions would need to be consistent with the Health and Safety at Work Act 2015 and the Holidays Act 2003. Workers must not feel compelled or coerced to return to work when they are unwell.

14. The guidance for critical health workers which had been developed under an earlier section 70 notice provides an example of how these exemptions could be specified and the types of infection prevention and control measures that might be required.

Resourcing implications

15. Our expectation is that these exemptions would respond to system issues raised through the incident management networks.

16. If there were a high volume of applications for exemptions directly to the Ministry, this would have resource implications for the Ministry.

S9(2)(h)

[redacted]

Next steps

19. If you agree, we will instruct the PCO to draft an amendment to the SRPW.

20. As noted above, we are also considering possible changes to the required isolation period for household contacts and cases. We will report on the outcome of this work shortly. Any changes would be progressed in a wider amendment order to the SRPW, likely next week.

Timing

21. It is proposed to make the amendments discussed in this report as a matter of urgency. This would involve a fast-track process as set out below.

22. Wednesday 2 March 2022:

- The Ministry seeks your agreement to make the amendments discussed in this report.

23. Thursday 3 March 2022:

- PCO drafts an SRPW amendment order;
- The Ministry provides you with an SRPW amendment order for Ministerial consultation.

24. As soon as possible, thereafter:

- you consult with your ministerial colleagues;
- PCO finalises drafting;
- the Ministry provides you with a signature draft of the SRPW amendment order;

- once signed and gazetted, the SRPW amendment order comes into effect, making the necessary amendment to the SRPW.

Recommendations

We recommend that you:

a) **Agree** to the Ministry instructing the Parliamentary Counsel Office to draft an amendment to the COVID-19 Public Health Response (Self-isolation Requirements and Permitted Work) Order 2022 (the Order) which would enable the Director-General of Health to allow certain workers to be exempted from the requirement for COVID-19 cases to isolate under the Order; **Yes/No**

b) **Note** that the Director-General, once enabled by the amended Order, would introduce an exemption which would apply to critical health workers;

c) **Note** that all exemptions enabled by the proposed amendment would be tightly restricted in terms of the workers and services to which they would apply;

d) **Note** that each exemption enabled by the proposed amendment would specify the circumstance and conditions under which cases could return to work and the required protective measures;

e) **Note** that the intention is for these exemptions to address system issues identified in the health system and the supply chain related to COVID-19; however, there may also be a significant volume of applications for exemptions directly to the Ministry;

f) **Agree** that this work should be carried out as a matter of urgency, with the aim of introducing an amendment to the COVID-19 Public Health Response (Self-isolation Requirements and Permitted Work) Order 2022 by Friday, 5 March 2022. **Yes/No**

s 9(2)(g)(i) [redacted]

Dr Ashley Bloomfield
Director-General of Health
Date:

Hon Chris Hipkins
Minister for COVID-19 Response
Date: 3/3/2022

Document 13

MINISTRY OF HEALTH
MANATŪ HAUORA

Memorandum

Availability and distribution of COVID-19 therapeutics for use in the community

Date due to MO:	17 March 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220456
To:	Hon. Chris Hipkins, Minister for COVID-19 Response Hon. Andrew Little, Minister of Health Hon. Dr Ayesha Verrall, Associate Minister of Health		
Cc:			

Contact for telephone discussion

Name	Position	Telephone
Jess Smaling	Acting Deputy Director-General, DHB Performance and Support	S9(2)(a)
Martin Chadwick	Group Manager COVID-19 Care in the Community	S9(2)(a)

Action for Private Secretaries

N/A

Date dispatched to MO:

To reinforce the message on the call earlier today, I expect the disability community to be actively considered in decisions around eligibility for access to these new treatments.
CH, 23/3/22

Document 13

MINISTRY OF HEALTH
MANATŪ HAUORA

Availability and distribution of COVID-19 therapeutics for use in the Community

Purpose

1. This report responds to your request for an update on the types, supply, and availability of COVID-19 therapeutics for community use.

2. This report also describes the operating model and implementation plan for how these medicines will be equitably and efficiently distributed. This includes discussion about the supply chain, clinical guidelines, monitoring, and oversight.

Background

3. Aotearoa is working towards a portfolio of COVID-19 therapeutics. The portfolio currently includes two oral antivirals: Paxlovid™ (nirmatrelvir with ritonavir) and molnupiravir; and two intravenous (IV) infusions: remdesivir and Ronapreve® (casirivimab and imdevimab).

4. A summary of COVID-19 therapeutics for community use is presented in **Appendix 1**.

5. Due to the worldwide demand for COVID-19 therapeutics, there are limited supplies available to Aotearoa.

6. Ensuring equitable and early access to COVID-19 therapeutics for priority populations, specifically Māori and other higher-risk groups, is imperative as they can reduce the risk of hospitalisation and severe disease.

7. Ronapreve® (casirivimab and imdevimab) is currently available for use in hospitalised COVID-19 patients and immunocompromised or unvaccinated patients in the community. It exhibited good efficacy against the Delta variant; however, has demonstrated significantly diminished potency against the Omicron variant. Therefore, it is outside the scope of this paper.

8. Tocilizumab and bariticinib are immunomodulators for use in hospitalised COVID-19 patients only and are not used in the community setting. They are also outside the scope of this paper.

Principles

9. Access to COVID-19 therapeutics needs to be safe, timely, equitable, efficient, effective, and patient-centred. These principles inform the approach discussed below.

Oral COVID-19 Therapeutics

Paxlovid™

Overview

10. Paxlovid™ is used in high-risk COVID-19 positive patients to reduce the risk of severe disease or hospitalisation.

11. Paxlovid™ treatment is a five-day course of two different oral tablets started on diagnosis and able to be taken when at home while experiencing mild disease.

12. Current evidence shows that Paxlovid™ is more effective at reducing hospitalisations than molnupiravir.

13. On 2 March 2022, Paxlovid™ was granted provisional consent by Medsafe for sale, supply, and use in Aotearoa for a period of two years.

Supply and eligibility

14. Pharmac has secured supply for a maximum of 60,000 patient courses of Paxlovid™ from Pfizer for 2022.

15. The initial shipment of Paxlovid™ is expected to arrive by April 2022. Stock will be limited and arriving in instalments. The size of each delivery is unknown at present, with negotiations ongoing.

16. Pharmac's consultation on the proposed access criteria for Paxlovid™ closed on 2 March 2022. Pharmac are currently reviewing the responses to this and expected to confirm the criteria in the week beginning 21 March 2022.

17. Pharmac will use an access criteria model that allows for rapid update if there are signs that demand is outstripping supply. The Health System Preparedness Programme (HSPP) will work with Pharmac and the Ministry of Health COVID-19 Therapeutics Technical Advisory Group to ensure equitable prioritisation of access to Paxlovid™.

Clinical guidance

18. As with all medications, COVID-19 therapeutics may have side effects and other clinical factors that need to be considered. In particular, Paxlovid™ has significant drug interactions.

19. Pharmac have contracted Mātui (He Ako Hiringa) to provide clinical resource to support the safe prescribing and dispensing of Paxlovid™. This guidance is currently in development and expected to be released by April 2022.

20. Clinical guidance will be incorporated into the Health Pathways section on COVID-19 and will be supported by webinars and online training.

Molnupiravir

Overview

21. Molnupiravir is an oral capsule administered as a five-day course and is able to be taken at home while experiencing mild disease by those at higher risk of severe disease or hospitalisation.

22. On 23 February 2022 Medsafe received a New Medicines Application from Merck Sharp & Dohme for molnupiravir approval for the treatment of COVID-19. An initial evaluation is underway.

23. Merck Sharp & Dohme will not supply stock until molnupiravir is approved for use.

24. Pharmac has secured supply for a maximum of 60,000 patient courses of molnupiravir from Merck Sharp & Dohme for 2022.

Supply and eligibility

25. Subject to approval, the initial shipment of molnupiravir is expected to arrive in April 2022. Stock will be limited and arriving in instalments. The size of each delivery is unknown at present, with negotiations ongoing.

26. Independent of the approval process, Pharmac initiated a consultation on the proposed access criteria for molnupiravir, which closed on 2 March 2022. Pharmac are currently reviewing the responses to this and expect to confirm the criteria in the week beginning 21 March 2022.

Clinical guidance

27. Molnupiravir does not exhibit the same significant drug interactions as Paxlovid ™ and standard clinical resources will be sufficient to enable safe and effective prescribing. These include the New Zealand Formulary and the Medsafe Data Sheet.

28. Clinical guidance will be incorporated into the HealthPathways section on COVID-19 and will be supported by webinars and online training.

Distribution plan for oral therapeutics

Premise

29. The COVID-19 Care in the Community programme has convened the COVID-19 New Therapeutic Implementation Group consisting of subject matter experts and sector representatives to prepare a distribution plan for oral COVID-19 therapeutics.

30. Planning for distribution is progressing through internal Ministry sign-off processes. Key components for distribution are described below.

Background

31. Pharmac will confirm wholesaler and distribution arrangements based on the following principles:

    a. The medicines will be listed as XPharm on the Pharmaceutical Schedule, meaning Pharmac has made alternative funding arrangements. Pharmacies must have a specific agreement that entitles them to distribute these medicines. This prevents these medicines being ordered by pharmacies who are not commissioned to provide the service and thereby supports national and regional stock control.

    b. Paxlovid™ and molnupiravir will be listed in the Pharmaceutical Schedule at zero cost as they have been purchased directly by Pharmac. Pharmac are finalising a dispensing and data capture process that is likely to be similar to that used for Maviret® (a hepatitis C treatment).

    c. A preferred wholesaler(s) will be identified and contracted by Pharmac to supply these medicines to commissioned pharmacies.

    d. The wholesaler distribution costs will be met by Pharmac's dedicated COVID-19 funding.

Proposed model

32. Stock of Paxlovid™ and molnupiravir will be limited, and during the surge there are likely to be more people eligible for treatment than courses available to supply.

33. Due to limited stock, DHB Pharmacy Portfolio Managers will lead a transparent process with the sector and Care Coordination Hubs to identify a limited number of participating pharmacies to enable effective stock management.

34. Participating pharmacies will be identified using a pro-equity, population needs-based approach. This will look different in each locality. More pharmacies may be required to provide the service in certain regions to ensure remote and high-need areas are appropriately serviced.

35. Only participating pharmacies will be able to order Paxlovid™ and molnupiravir from the wholesaler(s).

36. Supply chains will be carefully managed to minimise this risk of stock shortages in areas that need them the most. To support timely access to COVID-19 therapeutics these medicines will be front-loaded to participating pharmacies, with particular consideration for the needs of rural and remote localities.

37. General practitioners or prescribing clinicians will complete a clinical review, generate a prescription and send it to a participating pharmacy.

38. Participating pharmacies will clinically review the prescription, complete a medicines review, dispense the medicine, and organise delivery.

39. Pharmacies involved in the patient's care will provide information and advice to patients so that the medicines are taken safely and effectively.

40. COVID-19 therapeutics will be free to patients, funded through the COVID-19 Care in the Community budget approved by Cabinet on 20 December 2021 [CAB-21-MIN-0555].

41. Funding of $395.422 million will cover the cost of COVID-19 infection related primary care and kaupapa Māori and Pacific health services, which includes the cost of the general practice consultation and prescription for these medicines.

42. The funding approved by Cabinet also includes $25.304 million to cover the cost of pharmacist medicine management activities, prescription co-payments and delivery of the medicines to patients' homes.

Monitoring

43. Contracted wholesaler(s) will be required to send a daily report to the Ministry that describes how much stock they have and what has been distributed to each participating pharmacy.

44. The Ministry will monitor prescription data with reference to ethnicity, age distribution, and locality to ensure accountability with regards to equity and the Pharmac access criteria. The mechanisms for doing this are in development, and will be simplified by restricting dispensing to a smaller number of participating pharmacies.

45. Nationally collated data will be reviewed by the Clinical Quality Safety Governance Group and will be shared with Care Coordination Hub clinical governance groups.

46. The existing Centre for Adverse Reactions Monitoring (CARM) system will be used for reporting and monitoring adverse events. This is managed by the New Zealand Pharmacovigilence Centre who are contracted by Medsafe.

Intravenous COVID-19 Therapeutics

Remdesivir

Overview

47. Remdesivir is an antiviral medication that is administered as a series of three daily IV infusions in the community (the duration of therapy in the hospital settings varies depending on response to treatment).

48. Medsafe's approval process for remdesivir is ongoing. Remdesivir is currently being supplied as an unapproved medicine under Sections 25 and 29 of the Medicines Act 1981.

Supply and eligibility

49. Remdesivir is available for use in hospital, outpatient, and community settings.

50. The current stock of remdesivir in Aotearoa is limited. As of 17 March 2022, 460 courses of treatment were available at the wholesaler. A further shipment of approximately 1000 courses is expected in March and Pharmac is actively working to secure more stock.

51. Recent evidence informed a widening of Pharmac access criteria to include those in the early stage of illness who are at high risk of severe disease. There is currently insufficient stock to provide for all patients who meet the access criteria.

52. The Ministry of Health COVID-19 Therapeutics Technical Advisory Group is preparing national guidance based on Aotearoa evidence of the current Omicron outbreak to support the appropriate prioritisation and use of remdesivir in the community. This is planned for completion on 18 March 2022.

Clinical guidance

53. Clinical guidance for use of remdesivir in hospitalised patients is discussed in the "Clinical Management of COVID-19 in Hospitalised Adults (including in pregnancy)" guideline published on the Ministry of Health website (last updated 4 March 2022).

54. Clinical information about remdesivir is available on the New Zealand Formulary, with preparation and administration details in the product information sheet.

Distribution and administration

55. Remdesivir dispensing is currently restricted to District Health Board hospital pharmacies.

56. Access to outpatient or community infusions of remdesivir is determined locally and dependent upon local DHB supplies and capacity to provide, or collaborate to provide, infusion services in the community setting. For example, some DHBs have worked closely with local kaupapa providers to preposition remdesivir in their communities with known higher-risk patients.

57. There are concerns at a DHB level that current workforce capacity is insufficient to administer remdesivir across all community settings. Redeployment of district nurse workforce would come at significant opportunity cost. The small number of primary care providers who have indicated they could create capacity do not meet our expectations for equitable access. The ability to use surge workforce is limited due to the skillset required.

58. The Ministry will continue to work with stakeholders to identify workable solutions, acknowledging that an oral option is soon to be available which will meet the clinical needs of the same patient populations in the majority of cases.

Monitoring

59. The Ministry is working with DHB hospital pharmacies and Pharmac to develop a monitoring system for remdesivir.

Next steps

60. By 24 March 2022, the plan for the equitable distribution of oral COVID-19 therapeutics will finalised.

61. By 31 March 2022, the Ministry will report back on the confirmed monitoring systems for the COVID-19 therapeutics.

ENDS.

MINISTRY OF HEALTH
MANATŪ HAUORA

Appendix 1: Summary of secured COVID-19 therapeutics for use in the community

	Paxlovid™	Molnupiravir	Remdesivir	Ronapreve®
Presentation	Oral tablets	Oral capsules	IV infusion	IV infusion
Place in Therapy	Community use to reduce risk of hospitalisation and severe disease	Community use to reduce risk of hospitalisation and severe disease	Hospitalised patients & community use to reduce risk of hospitalisation and severe disease	Minimal effect against Omicron
Availability	Expected April 2022; limited stocks	Expected April 2022; limited stocks	Currently available; limited stocks in NZ	Currently available
Approval Status	Approved	Unapproved Application with Medsafe	Unapproved Application with Medsafe	Approved
Eligibility Criteria	To be confirmed by Pharmac	To be confirmed by Pharmac	Access criteria published on Pharmac website	Listed on the Pharmaceutical Schedule under Special Authority
Distribution Channel for Patient Access	Participating community pharmacies	Participating community pharmacies	DHB hospital pharmacy	Community pharmacy or DHB hospital pharmacy

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MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Transitioning the COVID-19 response functions to the new system structure in 2022

Date due to MO:	1 April 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220241
To:	Hon Andrew Little, Minister of Health		
Copy to:	Rt Hon Jacinda Ardern, Prime Minister Hon Grant Robertson, Deputy Prime Minister Hon Chris Hipkins, Minister of COVID-19 Response Hon Dr Ayesha Verrall, Associate Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Dr Ashley Bloomfield	Te Tumu Whakarae mō te Hauora Director-General of Health	S9(2)(a)

Minister's office to complete:

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

Comment:

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Transitioning the COVID-19 response functions to the new system structure in 2022

Security level:	IN CONFIDENCE	**Date:**	1 April 2022
To:	Hon Andrew Little, Minister of Health		
Copy to:	Rt Hon Jacinda Ardern, Prime Minister Hon Grant Robertson, Deputy Prime Minister Hon Chris Hipkins, Minister of COVID-19 Response Hon Dr Ayesha Verrall, Associate Minister of Health		

Purpose of report

1. This briefing provides advice and seeks your feedback on the Ministry's proposed approach to the delivery of the COVID-19 response in 2022 and addresses the report-back in SWC-21-MIN-0223.

2. This report discloses all relevant information and implications.

Summary

3. To respond to the demands of COVID-19, the Ministry has built substantial new functions, including establishing the COVID-19 Health System Response Directorate.

4. The COVID-19 response has created a legacy of system enhancements within the public health system to manage current and future public health threats. The development of the future public health model is underpinned by the principles that have guided the system through the COVID-19 response.

5. Our approach to the response has evolved as we have dealt with the Omicron peak and commence planning for managing the post-peak phase. We now have a better understanding of the changing nature of the response functions and broadly where the different response functions will sit in the new health system.

6. The Ministry (including the interim Public Health Agency) and interim Health NZ will undertake a detailed mapping and planning exercise to ensure that the functions are transferred in a way that maintains a strong response and mitigates any risk to the continuity of the response. In the first instance, the existing functions need to be assessed to ensure they are still relevant and right-sized for the future, e.g. the nature and size of the border health function has changed significantly in recent weeks.

7. This exercise will include mapping out the day-to-day activities and requirements so that the receiving entities have a clear plan for delivering the functions being transferred on day one. This will include ensuring clarity on leadership, accountability, monitoring and

reporting (including to Ministers). This, together with the final FTE transfers and transfer plans, will be reported back by late-April.

8. Our assessment is that functions that are going to be transferred will be ready to do so in the next four to six weeks. We will continue to regularly update you on progress towards the transfer including any emerging risks or issues.

Recommendations

We recommend you:

a) **Note** that the COVID-19 response has created a legacy of system enhancements within the public health system and that the development of the future public health operating model (PHOM) is underpinned by the principles that have guided the system through the COVID-19 response. **Yes/No**

b) **Note** that we have broadly determined the appropriate location for the COVID-19 response functions in the new system, including those that will transfer to iHNZ and the iPHA, and the next step is to assess in detail the focus and size of each functions to ensure they are ready for the next phase in the response to the pandemic. **Yes/No**

c) **Note** that our assessment is that functions that are to transfer will be ready to do so in the next four to six weeks. **Yes/No**

d) **Note** that to ensure appropriate risk-management, the Director-General, the Chief Executive of iHNZ and the Chief Executive of the iMHA, will agree on the timing of the transfer of the COVID-19 functions. **Yes/No**

e) **Note** that we will also undertake a detailed mapping and planning exercise to ensure that the receiving entities are able to carry out key day-day response activities, requirements and critical decision-making processes from day one, including monitoring and reporting. **Yes/No**

f) **Note** that the Ministry will report back in mid-April on the final FTE transfer and transfer plan following the completion of functions mapping exercise. **Yes/No**

g) **Note** that should the status of the outbreak or nature of the virus change significantly, the Director-General and the Chief Executives of iHNZ and iMHA will make an assessment about whether the transfers continue as planned, and whether any alterations to timing or approach are needed to mitigate emergent risks. **Yes/No**

h) **Agree** to forward this briefing to the Prime Minister, Deputy Prime Minister, Minister of COVID-19 Response and Associate Minister of Health (Hon. Ayesha Verrall) **Yes/No**

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Dr Ashley Bloomfield
Te Tumu Whakarae mō te Hauora
Director-General of Health
Date: 01/04/2022

Fepulea'i Margie Apa
Chief Executive, Health New Zealand
Date:

Hon Andrew Little
Minister of Health
Date: 3/4/22

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Transitioning the COVID-19 response functions to the new system structure in 2022

Context

1. New Zealand has led a strong health response to COVID-19, promoting positive public health, equity, wellbeing, and economic outcomes through the phases of the pandemic.

2. To meet the operational demands of the response, the Ministry of Health (the Ministry) created a new operating model, standing up a new COVID-19 Health Response Directorate and adding new functions across other parts of the Ministry. This has been mirrored by additional operating capacity within DHBs both locally and regionally to support delivery responses and work with the Directorate in implementation.

3. The pandemic is ongoing, and we are still in an active response. As is happening across government, the Ministry is reviewing its current COVID-related functions to ensure they are still relevant, and the right sized for the overall approach now being taken with the borders open and the shift in the way testing and contact tracing are done.

4. Our response is evolving rapidly and will continue to evolve post-peak of the Omicron outbreak as the Government makes further decisions about key response settings, including shifts in the COVID-19 Protection Framework, future approach to COVID-19 vaccination, and changes in isolation settings for cases and household contacts.

5. Through the COVID-19 response, we have created knowledge and experience, new models of care, and a legacy of enhancements across public health and the wider health system. These functions have transformed and enhanced the capability, perception, and relevance of the public health system and will form the basis of our future public health operating model (PHOM).

6. In 2022, the COVID-19 response will evolve further as the COVID-19 pandemic continues to evolve, most likely towards an endemic disease, and parts of the response become embedded into the transformed health system.

7. Progressing with the transfer of the COVID-19 operational functions to Health New Zealand is consistent with the overall health and disability sector reforms. It will support the Ministry to strengthen its stewardship role and continue to provide national leadership and for Health New Zealand (Health NZ) to deliver integrated response and the Maori Health Authority to continuously improve responsiveness to Maori.

8. Within the transfer planning, it will be critical to ensure a stable handover of the current response while the pandemic continues and we have an active Omicron outbreak, with an expected ongoing level of diseases through winter and potential further peaks. In addition, functions transfer need to align with the future system public health operating model, the roles, and responsibilities for the system entities (including the Public Health Agency) and at a high-level view of how they cohesively fit together as part of the wider health system.

9. This briefing updates you on our agreed approach and timeframes for transferring the relevant COVID-19 response functions to the new health system entities and addresses the report-back requested in SWC-21-MIN-0223.

Current COVID-19 functions within the Ministry

10. To respond to the demands of COVID-19, the Ministry has built substantial new functions within the COVID-19 Health System Response Directorate in July 2020. This directorate pulls most of the Ministry's COVID-19 operational activity into a central place to provide consolidated pandemic stewardship, science, and public health advice to Ministers, and guide the sector to respond quickly and effectively.

11. Under the COVID-19 Response Directorate, we have developed several new functions including a national contact tracing and case investigation service, a new clinical management system and new testing modalities with national oversight. In addition, national approaches pre-existing functions were developed to deal with the extraordinary circumstances and the need for national consistency and certainty e.g. PPE supplies and logistics. These functions are a key part of the legacy that the COVID-19 response leaves for the health system.

12. Clear national leadership and an integrated approach has been critical at a time of complexity and ambiguity and has enabled the system to adapt quickly and efficiently to changing threat of the virus over the past two years.

13. Over the last 18 months, the COVID-19 Health Response Directorate's workload has increased as the response to the pandemic has evolved with significant increases in reporting requirements, additional support provided to the sector and increased support for teams managing borders, border exemptions, and MIQ activities.

14. The COVID-19 Directorate is also supported by many other parts of the Ministry, which have also pivoted from their 'business-as-usual' roles to support planning and response activities. We have also built significant work programmes and teams within the Health System Preparedness Programme, Care in the Community and the COVID-19 Vaccination and Immunisation Programme (CVIP).

COVID-19 Vaccination and Immunisation Programme

15. Operating alongside the COVID-19 response is the COVID-19 Vaccination and Immunisation Programme (now part of the National Immunisation Programme) that leads operational planning and guidance. The programme works closely with other parts of the Ministry, including:

    a. Policy and Strategy (sits within SSP): leading the strategy and policy advice to support the COVID-19 immunisation programme

    b. Purchasing (sits within SSP): management of COVID-19 vaccine portfolio, including Advanced Purchase Agreements and participation in COVAX.

16. The COVID-19 Vaccination and Immunisation programme was started with a view that, through the course of running the vaccine programme, the Ministry will take incremental steps to transition from a COVID-19 focused programme to a more strategic approach focussing on all immunisations more broadly [SWC-21-MIN-0223 refers].

17. The NIP is now planning for and ready to deliver a strengthened approach to all immunisation programmes (alongside the COVID-19 vaccine programme) that leverages

communications, analytics and other operational functions and lessons from the COVID-19 Vaccine and Immunisation Programme.

18. The NIP itself is a key public health programme that will be delivered by Health New Zealand, with some key service commissioning by the Maori Health Authority, and as such it will transfer to those organisations.

Leveraging the current operating model to strengthen the future public health system

19. The COVID-19 response has created a legacy of system enhancements within the public health system to manage current and future public health threats.

20. The development of the future public health model is underpinned by the principles that have guided the system through the COVID-19 response, as well as the goals of the health system reform. Critically, the aim in the future is to create a public health operating model (PHOM) that is nationally consistent and regionally responsive.

21. While the PHOM leverages the success of COVID-19, it also considers the challenges and opportunities within the current public health system. For this reason, the transfer of functions needs to be consistent with the new PHOM and the roles and responsibilities set out in the future model of public health.

22. Under the PHOM, the core COVID-19 response functions will be distributed according to how these fit within the roles and responsibilities of the new entities, as determined under the Pae Ora Bill:

    a. **Ministry of Health:** Act as the chief steward of the health system, including setting direction and expectations for the system and its entities, and the lead advisor to Government on matters relating to health, led by the Director-General of Health. The functions would involve a trio of policy; strategic public health; and chief science advice input

    b. **Public Health Agency**: Provide all public health and population health strategy, policy, regulatory, intelligence, surveillance and monitoring functions. The PHA will also work with Health NZ and Māori Health Authority to plan for public health promotion, prevention and protection programmes.

    c. **Health New Zealand**: Health NZ will support the capability of the health system, promote resilience within the system and ensure that the system is able to respond to surges in demand. As part of Health NZ The National Public Health Service (NPHS) will provide public health resources and leadership where required. HNZ will work closely with the Māori Health Authority to ensure responsiveness to Māori remains a core principle of all operations.

    d. **Māori Health Agency**: Work in partnership with the Ministry in shaping system policy and strategy to ensure performance for Māori. As co-commissioner ensure preparedness and development of Kaupapa Maori providers are capable to respond to communities. Partner with Health NZ to commission public health services across New Zealand and mitigate impact on clinical service delivery and equity of access, ensuring that the needs and expectations of Māori communities are also centred in design and delivery.

Transitioning from the immediate to a future state of the public health system

23. The current focus of the response is on managing ongoing impact of Omicron, reconnecting with the world, and planning for managing COVID-19 through the winter. Beyond this we are also working across Government to plan our future and longer-term approach to COVID-19.

24. Our approach to the response has evolved as we have dealt with the Omicron peak and commence planning for managing the post-peak phase. We now have a better understanding of the changing nature of the response functions and broadly where the different response functions will sit in the new health system.

25. Progressing with the transfer of the COVID-19 operational functions to Health New Zealand is consistent with the overall health and disability sector reforms. It will support the Ministry to strengthen its stewardship role and continue to provide national leadership and for Health New Zealand (Health NZ) to deliver integrated response and the Maori Health Authority to continuously improve responsiveness to Maori.

26. Within the transfer planning, it will be critical to ensure a stable handover of the current response while the pandemic continues and we have an active Omicron outbreak, with an expected ongoing level of diseases through winter and potential further peaks. In addition, functions transfer need to align with the future system public health operating model, the roles, and responsibilities for the system entities (including the Public Health Agency) and at a high-level view of how they cohesively fit together as part of the wider health system.

Transition and location of the COVID-19 Health Response Directorate's functions to new health entities

27. To date, we have carried out a series of hui with representatives from the Ministry, Health New Zealand (HNZ), and the Māori Health Authority (MHA) to develop a joint position on the location of functions and our approach to transferring them.

28. The agreed future locations for functions in the COVID-19 Response Directorate (the Directorate) are set out in **Table 1 below.**

29. The FTE numbers in Table 1 are the current numbers that have been provided to you to give a sense of the size of these current functions.

30. As is happening across government, many of the COVID-19 functions need to change for the next phase, including changes in the overall settings and approach. In particular, the number of FTEs will change and, in some cases, reduce considerably. A process of right sizing will need to occur as part of transfer exercises (more information below).

31. Equity is a critical cornerstone of the reformed health system. As we transfer the functions of the Directorate to respective entities, it is expected that equity as an outcome is embedded across the system.

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Table 1. Future of the COVID-19 Health Response Directorate Activities

Group (*current FTEs*)	**Emerging function**	**Receiving entity**
National Investigation and Tracing Centre (NITC) (~69 FTE)	NITC manage large national contact tracing service and a national case investigation service. The function has changed to support self-management of COVID-19.	**HNZ (NPHS)**
Public Health Operations Group (~ 12 FTE)	PHOG provides national public health leadership, coordination, and tactical direction for the management of case and contacts for COVID outbreaks.	**HNZ (NPHS):** Operations and tactics **PHA:** High level policy
Border Operations and MIQ (~36 FTE)	The team works on border operations, MIQ operational guidance, Health Order enforcements/exemption. Their processes and systems have been refreshed for reopened borders (incl. shifting focus on managing MIQ to supporting travellers to self-isolate). This team will need to be smaller and with a different focus in future.	**HNZ (NPHS):** Operational design **PHA:** Strategic approach to health at the border as part of Border Executive Board work programme
Testing and supply (~62 FTE)	Regulation and Accreditation: of approved COVID-19 test types, Testing Operations: Responsible for the operationalisation of testing strategy, procurement and contracting of private testing laboratories. Supply: Provide national coordination of supply chain of PPE/critical clinical supply. The systems for supply, procurement, distribution, and logistics is intended to be used beyond just testing kits. Project management of critical and ongoing projects.	**PHA:** Regulation and accreditation **HNZ (NPHS):** Procurement and contracting of providers. Supply and project management
Science and insights (~51 FTE)	Public health intelligence and surveillance, expert technical and science advice, evidence-based insights to guide decision-making, secretariat for Technical Advisory Groups. Focus remains on providing daily reporting and insights to support our strategic response. In time, this would shift to include wider disease surveillance as is needed by the system.	**PHA:** Noting that there will be analytical and insights capability and capacity in HNZ (including the NPHS) and the MHA.
Response and coordination (~29 FTE)	Provides incident management, coordination of response activities, operational reporting, and monitoring and response to enquiries and requests for information about the response. Note this function will be smaller and have a different focus in future.	**HNZ:** Co-ordinates the national operational aspects of the response, working closely with the four regional response teams **MOH**: Part of AOG response and coordination of cross-government operational aspects of the ongoing response
COVID-10 Strategic Operations	Maintains strategic linkages across the Directorate teams and provide strategic operational and equity advice on implementation of the COVID-19 response.	**MOH:** Part of AOG response including ongoing Strategy and

(~29 FTE – including ODCE)	Note this function will be smaller and likely combine with the Response and Coordination function.	planning across government **HNZ (NPHS)**
Office of the DCE	Advisory and business support, privacy advice, operational planning and programme management	**HNZ (PHNZ)**: combined with strategic operations team **MOH**: privacy function will move to Health Legal team within Ministry.

COVID-19 Vaccination and Immunisation Programme

32. The COVID-19 vaccination programme has transitioned to an integrated National Immunisation Programme that focuses on immunisations broadly.

33. There has been in-principle agreement that the National Immunisation Programme roles will transfer to HNZ, with the final number and timing to be confirmed [DPMC-2021/22-1221].

34. The vaccine policy and strategy functions will transfer to the Public Health Agency.

35. There has been in-principle agreement to transfer responsibility of ongoing vaccine purchasing from the Ministry of Health to Pharmac [SWC-21-MIN-0223 refers]:

    a. It is timely to transition vaccine purchasing functions for COVID-19 to Pharmac alongside consideration of the wider Pharmac review and Health and Disability System reforms.

    b. It is crucial that with the transfer of vaccine purchasing functions that the outcomes focused approach and COVID-19 response are maintained as we continue to mitigate the impacts of COVID-19 on New Zealand and the health system.

36. Ministry of Health will report-back to Social Wellbeing Committee in May 2022 with further details on transferring the responsibility for the on-going management and purchase of COVID-19 Vaccines from the Ministry of Health to Pharmac, and the reallocation of the COVID-19 Vaccine and Immunisation Programme to the Public Health Service in Health New Zealand.

Transfer of related COVID-19 functions

37. The scope of the paper is limited to discussing the final location and timing of the transfer of functions within the COVID-19 Health Response Directorate. The details around the related functions which are scheduled to migrate will do so at their own specified times.

38. We have signalled below the location of the related functions that work closely with the COVID-19 response functions:

    a. **the Office of the Director of Public Health**: provide ongoing significant public health leaders and advice to the Ministry. The team will move to the Public Health Agency within the Ministry of Health and provide direct leadership to the national public health service in Health NZ (CAB-21-MIN-0092 refers).

    b. **Health System Preparedness and Care in the Community programme** (lead out of DHB performance and support directorate) was developed in 2021 as the

operational lead for supporting people to isolate and recover at home and provide support to sector to deal with increased demand. The team is still in active response mode; future need for and location of this work programme is still to be determined.

c. **System Strategy and Policy (SSP)**: the COVID-19 Policy and Strategy function sits within the SSP directorate and will remain within the Ministry to support the long-term strategic approach across government and the development of policy, legislation, and Orders.

d. **Data and Digital:** focused on the delivery of technology solutions and services which support the COVID-19 response, including contact tracing, border solutions COVID-19 tracer app and vaccine programme. This function will move to Health NZ (four of the nine teams have already shifted under Tranche 1 [DPMC-2021/22-1221]).

e. **Communications**: works to provide comprehensive public health campaigns that allowed populations to understand the measures in place. The function will shift to Health NZ as part of tranche 2 transfers.

f. **Global Health**: responsible for the vaccine roll outs to the Pacific and supporting Pacific health responses to COVID-19 as part of the Pacific Corridors. The function will remain in the Ministry.

Equity and Te Tiriti o Waitangi

39. As articulated by the Courts and the Waitangi Tribunal, equity is a principle of Te Tiriti, and one of the principles recommended by the 2019 Hauora report for the Health system is Equity.

40. Within this principle, it is critical to ensure that the any function transfer planning is developed and implemented with hauora Māori at the forefront is crucial for achieving positive health outcomes and meeting the Crown's obligations.

41. Planning of the future health system has been rigorous in positioning the Māori Health Authority and Health New Zealand to respond to the goals of the health reforms and the aspirations of te ao Māori.

42. The reforms aim to strengthen rangatiratanga Māori over hauora Māori, empower Māori to shape care provision, and give real effect to Te Tiriti o Waitangi. Initiatives throughout the COVID-19 response (such as Māori-led immunisation campaigns) have shown the massive impact Māori leadership can have on achieving equity.

43. Māori Health Authority, Health New Zealand, and the Ministry of Health will continue to build the relationship needed to work together in creating a joined-up system that is fair, equitable, and founded on Te Tiriti. For this, the entities must lead and model partnership across the sector to ensure equitable outcomes are enabled.

44. Specific to the proposal in this paper, it is also critical to ensure that we manage any risks the transfer may present in relation to hauora Māori and equitable outcomes for at-risk populations.

45. A devolved system needs to continue work together to uphold the integrity of the response functions and ensure that services are being delivered in a culturally competent manner to reduce additional health risks. It is thus recommended that the

proposed readiness assessment comprehensively evaluates the specific impact of any functions transfer on equity.

46. The entities are working together to ensure that te Tiriti and partnership with Māori is at the centre of design and delivery of the public health system – from strategy and policy to delivery and operations. There is also an explicit focus on embedding a population and equity centred approach for Māori, Pasifika, disabled peoples and other priority groups. The entities are also using the learnings and system enhancements from the continuing pandemic response and sector engagement to inform the continued development and implementation of the PHOM.

Timing and conditions for transitioning the COVID-19 response functions to new entities

47. Our planned approach to transferring functions is centred on ensuring that we transfer functions as soon as they are ready and the core elements are in place in the receiving agency, but also in such a way that ensures critical response functions continue without disrupting the response.

48. The following contextual factors have been considered while proposing the timing of the COVID-19 functions transfer to respective entities:

    a. **Operational readiness:** the key response functions are mapped out and understood, and an operating approach agreed to ensure the critical response functions continue without disruption.

    b. **Status of the response**: while the pandemic is still ongoing and response is ongoing, as the response evolves, many extant COVID-19 functions will either no longer be necessary in their current form, e.g. support for managed isolation and quarantine, or will be ready to become embedded in the wider health system as part of the long-term shift from crisis response to sustainable prevention and management of COVID-19.

49. The Ministry's assessment is that functions that are to be transferred will be ready to do so approximately four to six weeks from now. While some functions may be ready to transfer from 1 May 2022, the focus is on ensuring the functions are the right ones and the right size, and that everything is in place for a smooth transfer.

50. During this time, the Ministry and Health NZ will undertake a two-step process to prepare the functions for transition to the respective entities:

Step 1: Scoping of the functions

51. Officials from the Ministry and Health NZ will review the leadership, accountability and monitoring requirements for each function, and determine what is needed to deliver in the new system.

52. Through this exercise, we will also outline the functions that are new capabilities as compared to teams that have pivoted from 'business-as-usual' in order to deliver the COVID response.

53. Where relevant, we will retain the original purpose in the system, and maintain the appropriate capability to embed the legacy systems as part of the strengthening of the public health system. This will ensure entities are able to respond better to communicable diseases that are an ongoing challenge including sexually transmitted

diseases, foodborne illness, and vaccine preventable diseases, e.g. measles and pertussis, and/or represent a significant enhancement of previous functions, such as expanded contact tracing and improved logistics functions.

Step 2- Right-sizing process

54. The requirements of each function will then be used to determine the FTEs required to deliver the new system.

55. It can be expected that some functions likely to be much smaller, e.g. border management function), and/or are no longer needed at the same scale, e.g. those servicing the extensive reporting, while some will be 'new' functions in the wider system e.g. national contact tracing.

56. A change process will then be initiated with affected staff and timing for the functions to be transferred will be finalised.

Conditions for transferring the functions

57. To ensure appropriate risk management, the Director-General of Health, the Chief Executive of Health NZ, and the Chief Executive of Māori Health Authority, will make the final decision on the timing of the transfer of COVID-19 functions. The decision will be made using the following set of conditions:

a. *Agencies are sufficiently ready to receive COVID-19 functions*: Director-General and the Chief Executives of Health NZ and Māori Health Authority agree structures, processes, leadership, capacity and capability to receive the COVID-19 functions and deliver the response are in place.

b. *Risk management and monitoring*: Director-General and the Chief Executives of Health NZ and Māori Health Authority agree risks associated with the transfer of the functions and a mitigation, the process for assessing trade-offs of mitigation actions is jointly agreed in the transfer including financial or delivery risks

c. *Communication*: significant stakeholders agreed by the Director-General and the Chief Executives who are impacted by the transition have the necessary information to understand the changes, including the processes, systems, and associated accountabilities.

d. *Oversight in place*: the Director-General and the Chief Executives agree the monitoring framework for assessing system performance approach and a framework in place to both monitor the reform activities and provide Ministers required information as part of ongoing oversight of Health NZ as a whole.

e. *Equity embedded*: the Director-General and the Chief Executives agree priority areas for equity focus and work programmes in place to assure impact and engagement of those stakeholders are in place. We must also ensure monitoring forms part of how we ensure equity is being embedded in services.

58. The process will impact priority stakeholders, all of whom will be consulted as part of finalising the transfer process. This includes the relevant Ministers, DPMC as the lead on the AOG response, and (for the time being) District Health Boards.

59. It is also recommended that all the functions transfer on the same date unless there is merit in transferring a function earlier. A single transfer date will make it easier for staff to have clarity about when they're transferring and will make it easier for entities to receive the transferring functions.

60. Should the status or nature of the virus in the community change the Director-General and the Chief Executives of Health NZ and Maori Health Authority will make an assessment about whether the transfers continue as planned, and whether any alterations to timing or approach are needed to mitigate the risk.

Managing the risks associated with transferring functions

61. Transferring the functions across entities is not without risk, particularly at a time when the health sector is responding to multiple demands and pressures.

62. The due diligence process that we have followed for transfer decisions to date will surface any existing risks to performance of the function, along with risks that may emerge as a result of transfer. Where possible, functions are transferring with existing leadership and with teams as intact as possible to ensure continuity of the day-to-day work.

63. There are three key risks in transferring of response functions:

    a. The key risk with transferring of response functions while the response in underway is the potential loss of connections between different contributing elements of the response, and lack of clarity about how to join up different elements when devolved to different entities. Ongoing work to plan the operating approach to delivering the work in a devolved system is intended to mitigate this risk.

    b. There is also a risk that the nature of the virus in New Zealand changes between now and the transfer of functions, for example through the introduction of a new variant of concern, or there is a significant spike in infections and pressure on the health system as part of the current Omicron outbreak. Should either of these happen the Director-General and the Chief Executives will make an assessment about whether the transfers continue as planned, and whether any alterations to timing or approach are needed to mitigate the risk.

    c. The health sector has been actively responding to COVID-19 for more than two years now; this has taken a toll on the front-line workforce and as a result the sector may be less able engage in change and be ready for it. There are also some expectations that the system will transform from Day 1 rather than it being a transition date and the start of a process of transformation. This is being managed by clear agreement that stable transition is the primary goal and that we will utilise the new structures and partnerships to transform over a longer period.

64. Following tranche 1 of function transfers, the Ministry, jointly with the interim entities, conducted a 'lessons learned' exercise to identify risks as well as the opportunities to improve on planning approaches, processes and decision making. This will inform the way we undertake transfers of other functions, including those COVID-19 functions currently operating within the Ministry.

Next steps

Approach to finalising functions transfer

65. The Ministry and Health NZ will undertake the above-mentioned two-step change transfer process of scoping and right-sizing of the COVID-19 functions.

66. The Ministry is also creating a plan to ensure that equity considerations remain central through the transfer.

67. We will seek your approval on the final transfer plans by late-April, including leadership, accountability, and monitoring/reporting arrangements.

68. Further from this, officials will keep you updated regularly on progress towards the transfer including any emerging risks or issues.

Related report backs and work

69. There will be a separate report back from the Ministry and Transition Unit to the Minister of Health and Associate Ministers of Health (Hon Dr Ayesha Verrall and Hon Peeni Henare) in April 2022 on further progress in developing the PHOM and public health function transfer to the new public health entities.

70. The Ministry of Health will report-back to Social Wellbeing Committee in May 2022 with further details on transferring the responsibility for the on-going management and purchase of COVID-19 Vaccines from the Ministry of Health to Pharmac, and the reallocation of the COVID-19 Vaccine and Immunisation Programme to the Public Health Service in Health New Zealand.

71. Officials will also report back on the long-term trajectory and strategic direction for COVID-19, including our transition into living with COVID-19 as an endemic virus (joint Health and DPMC lead, reporting to Hon Chris Hipkins) by the end of April 2022.

72. The Ministry is currently planning a review of the New Zealand Influenza Pandemic Plan (NZ IPAP), which was last updated in 2017. The NZ IPAP was derived from past experience with influenza, however the plan needs to be revised significantly in light of COVID-19. Through the review, the Ministry will outline the tools and that are required to guide the system through future pandemics (not just influenza related ones) and respiratory illnesses more broadly.

Financial implications

73. Funding for COVID-19 response functions has been approved at different points and for different time periods due to the emerging nature of the pandemic and the required response to it. As a result, different areas of the response, such as testing, managed isolation and quarantine (MIQ) and Ministry resources, are all funded to different points in time.

74. The nature of the funding required for our ongoing response to COVID-19 is determined by the nature of the response and approach as we adapt our functions to address the current Omicron wave and then transition them into a response to COVID-19 as an endemic virus. The location of these functions across the transformed health system does not significantly impact on the resourcing required for these functions.

75. More details of the financial implications and requirements for the ongoing COVID-19 response are set out in the upcoming Cabinet paper detailing 'funding of the health system response to COVID-19 in 2022/23'. The paper includes information on the following areas, and further work continues to address the financial implications of the other areas of the response:

    a. Ongoing testing, tracing, isolation and quarantine

    b. Health system preparedness (including care in the community programme)

    c. Reconnecting New Zealanders

76. Confirmation of funding is also required to the National Immunisation Programme management currently in the Ministry of Health. All positions in the Programme are scheduled to end on 30 June 2022 due to uncertainty of on-going funding and where the Programme will be placed in the upcoming system reforms taking effect from 1 July 2022. Cabinet will be provided with a separate report in the next two weeks around decisions on 'funding of the National Immunisation Programme into 2022/21'.

Consultation

77. The briefing has been consulted across key partners in the transition process, including the Public Health Agency, interim Health NZ, interim Māori Health Authority and the Transition Unit.

78. The consultation discussions focused on the timing for transfers, the evolving nature of the functions and the process to land their eventual size, and the expression of the importance of equity in this work.

79. COVID-19 functions were always planned to be transferred through a process that was independent of other 'business-as-usual' health functions. This has allowed the process to have both the agility and the speed that is required in a time when the pandemic is still ongoing, and we are required to maintain a full-functioning response.

80. Further this agility is needed especially given the speed at which the Government's response to COVID-19 is evolving. As mentioned earlier, there is a cross-government process that is happening to determine the where key COVID-19 response functions and their leadership occur in future and the health COVID-19 functions transfer work needs to be seated within this context.

81. Seeking independent facilitation by PwC has created momentum around the COVID-19 functions transfer. We recommend maintaining this momentum and will come back shortly with the details outlined in the 'next steps' section.

ENDS.

Document 16

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

COVID-19 Health System Response: Oxygen Supply and Environmental Issues

Date due to MO:	1 April 2022	**Action required by:**	NA
Security level:	IN CONFIDENCE	**Health Report number:**	20220582
To:	Hon Chris Hipkins, Minister for COVID-19 Response		
Cc:	Hon Andrew Little, Minister of Health Hon Dr Ayesha Verrall, Associate Minister of Health Hon Grant Robertson, Minister of Finance		

Contact for telephone discussion

Name	Position	Telephone
Darryl Carpenter	Group Manager – Testing and Supply, Ministry of Health	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Document 16

COVID-19 Health System Response: Oxygen Supply and Environmental Issues

Security level:	In Confidence	**Date:**	1 April 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose of the report

1. This report provides an update on improving the District Health Board (**DHB**) infrastructure that supplies oxygen for COVID-19 patients, and manages the related air-handling environment.

Summary

2. In October 2020, joint Ministers approved $35M of funding aimed at improving oxygen supply and environmental control (air management) systems at 12 DHBs.[1] The associated programme was based on preparing for an all-of-government planning scenario of 5,000 COVID-19 cases nationwide, with a hospitalisation rate of 150 Intensive Care Unit (**ICU**)-level and 600 ward-level patients (150/600 planning scenario).

3. The programme has now implemented infrastructure and air management systems across the DHBs identified,[2] having delivered on its principal goals of ensuring

   - availability of oxygen supply to meet the demand forecast in the 150/600 planning scenario; and
   - improvements made in air management for selected COVID-19 treatment spaces.

4. All DHBs in the main centres (Auckland, Canterbury, Capital and Coast, Counties Manukau, Dunedin, Hawke's Bay, Lakes, Northland, and Waitemata) now have adequate bulk oxygen supply and storage in place.

5. The oxygen medical gas supply chain has been prepared to scale up if necessary, with protocols in place across all 20 DHBs – including portable emergency oxygen capacity that can be dispatched to any DHB at short notice.

6. At some DHBs, finishing works to complete final aspects of the upgrade are being carried out. These works include installing two new oxygen vessels at MidCentral and Hutt Valley DHBs, with specially designed and manufactured oxygen tanks due to seismic requirements. Both DHBs have solutions in place ready for the new tanks to arrive.

[1] Bay of Plenty, Canterbury, Capital and Coast, Counties Manukau, Hawke's Bay, Hutt Valley, Lakes, MidCentral, Northland, Tairawhiti, Taranaki, and Waitemata DHB.

[2] Of the 12 DHBs funded, two DHBs (Canterbury and Taranaki) did not require bulk oxygen facility upgrades. Canterbury had sufficient capacity, and Taranaki was being upgraded through Project Maunga.

7. The programme is forecast to be completed with sufficient contingency for additional works at Nelson Marlborough, Wairarapa, and Waikato DHBs that currently have marginally-rated oxygen supply systems. These works will result in strengthened oxygen supply, and remove a remaining DHBs limitation in responding to a potential significant surge in COVID-19 cases.

8. The Ministry intends to have the oxygen upgrade programme mostly completed by the end of June 2022, with the remaining close-out works having no effect on achieving the programme objectives. Please refer to **Appendix 1** for the full progress update.

9. The contract close-out actions and management activities (such as warrantee and defect liability periods) will be managed by the Health Infrastructure Unit (**HIU**) in consultation with the relevant DHBs.

Recommendations

We recommend that you:

1	**note** that the main objectives of the oxygen supply and environmental issues programme have been delivered, with sufficient oxygen supplies for the national 150/600 planning scenario established;	Yes/No
2	**note** that of the 12 DHBs identified under the oxygen supply and environmental issues programme, only ten DHBs required bulk oxygen facility upgrades (Canterbury DHB had sufficient capacity, and Taranaki DHB was being upgraded through Project Maunga);	Yes/No
3	**note** that in addition, bulk oxygen facility upgrades are being delivered for Nelson Marlborough, Wairarapa, and Waikato DHBs, resulting in bulk upgrades to 13 DHBs in total (Northland, Waitemata, Counties Manukau, Waikato, Lakes, Tairawhiti, Bay of Plenty, Hawke's Bay, MidCentral, Hutt Valley, Capital and Coast, Nelson Marlborough, and Wairarapa);	Yes/No
4	**note** that some final completion works remain in progress, with the programme expected to close out by the end of June 2022; and	Yes/No
5	**note** that at programme close-out, some limited items (presenting no risk for oxygen supply) will remain for MidCentral and Hutt Valley DHBs due to a very long lead time for seismically-rated oxygen storage vessels.	Yes/No

Bridget White
Deputy Chief Executive
COVID-19 Directorate
Date: 31 March 2022

Hon Chris Hipkins
Minister for COVID-19 Response
Date: 5/4/2022

COVID-19 Health System Response: Oxygen Supply and Environmental Issues

Background

1. In October 2020, following Cabinet approval of a COVID-19 funding package [*CAB 20 MIN 0328.25 refers*] and submission of a detailed business case, joint Ministers approved $35M of funding aimed at improving oxygen supply and environmental control systems.

2. This business case was prepared in response to an all-of-government planning scenario of 5,000 COVID-19 cases nationwide, with a proportionate population-based hospitalisation rate of 150 Intensive Care Unit (**ICU**)-level and 600 ward-level patients (150/600 planning scenario).

3. The business case identified 12 DHBs (Bay of Plenty, Canterbury, Capital and Coast, Counties Manukau, Hawke's Bay, Hutt Valley, Lakes, MidCentral, Northland, Tairawhiti, Taranaki, and Waitemata) which might struggle to provide oxygen in this scenario, and improvements in air management systems were required to reduce the risk of oxygen concentration levels and COVID-19 airborne transmission, both of which pose a health-and-safety risk to patients and staff.

4. It was further determined that only 10 DHBs out of 12 DHBs above required bulk oxygen supply upgrades. Contingency work is now also being done at Nelson Marlborough, Wairarapa, and Waikato DHBs that currently have marginally-rated oxygen supply systems.

5. Our last update on implementing the programme of work associated with this business case was provided on 11 November 2021 [*HR20212282 refers*].

Progress to date

6. All parts of delivery (including hospital access and capacity, supply chain, consultants, and contractors) have been affected by the Omicron outbreak with the high number of COVID-19 cases. To date, the risk of its negative impact has been minimised through close cooperation with DHBs and excellent contractors and consultants performance.

7. The programme is now in its closing stages, having implemented infrastructure and air management systems across the DHBs identified, and delivered on its principal goals of ensuring

   - availability of oxygen supply to meet the demand forecast in the 150/600 planning scenario; and
   - improvements made in air management for selected COVID-19 treatment spaces.

8. The oxygen medical gas supply chain has been prepared to scale up if necessary, with regular and emergency protocols (to increase the national manufacture, storage, and delivery of oxygen) in place across all 20 DHBs – including portable bulk emergency oxygen storage and conversion capacity that can be dispatched to any

DHB at short notice.

9. All DHBs in the main centres (Auckland, Canterbury, Capital and Coast, Counties Manukau, Dunedin, Hawke's Bay, Lakes, Northland, and Waitemata) now have adequate bulk oxygen supply and storage in place through a combination of existing and improved infrastructure.

10. The remaining works remain at risk of delay due to the impact of COVID-19. However, these remaining works do not affect the delivery of the achieved programme benefits.

11. We are monitoring overall national oxygen use associated with the Omicron surge. So far, the increase in total oxygen use has been marginal (generally, use of oxygen decreases when the number of COVID-19 cases increases – as a result of deferring elective procedures).

Remaining works

12. Finishing works are being carried out at some DHBs – for example, where access for COVID-19 treatment is restricted or where temporary works are being made permanent.

13. MidCentral and Hutt Valley DHBs have required specially designed and manufactured liquid oxygen storage tanks due to seismic requirements (any new cryogenic liquid oxygen storage tanks must be significantly stronger than older ones).

14. To ensure that the design requirements are appropriate, a second design consultant peer-reviewed the primary consultant's recommendation, confirming the requirement for stronger tanks which will require up to six months to be delivered from the United States.

15. Both DHBs have solutions in place to provide additional bulk oxygen before the new tanks are installed.

16. The programme is forecast to be completed with sufficient contingency for additional works at Nelson Marlborough, Wairarapa, and Waikato DHBs that currently have marginally-rated oxygen supply systems. These works will result in strengthened oxygen supply, and remove a limitation in responding to a potential significant surge in COVID-19 cases.

Programme close-out

17. The Ministry intends to have the oxygen upgrade programme mostly completed by the end of June 2022, with the remaining close-out works having no effect on achieving the programme objectives. Please refer to **Appendix 1** for the full progress update.

18. The contract close-out actions and management activities (such as warrantee and defect liability periods) will be managed by the HIU in consultation with the relevant DHBs.

19. The programme remains on track to deliver within the allocated budget. At this stage, we estimate that the programme may come in $1-2M under budget. No DHB capital

contributions were required as was first projected under this programme.

Links to the Rapid Hospital Improvements Programme (RHIP)

20. The Ministry is advancing the COVID-19 RHIP which is being reported on separately.

21. Parts of the RHIP programme are very similar to the Oxygen Supply and Environmental Issues programme. Experience gained and lessons learned from the latter have informed and assisted the RHIP.

Next steps

22. We will continue to focus on completing the Oxygen Supply and Environmental Issues programme with urgency, in consultation and collaboration with the HUI and DHBs.

23. We will maintain a strong focus on achieving a timely and organised close-out of the programme by the end of June 2022, noting that some remaining close-out works will remain.

24. The HIU will oversee the delivery of the remaining close-out work, and manage the contracts to completion.

ENDS.

Appendix 1: Progress Update, 31 March 2022

DHB	Status	O2 Bulk Storage	O2 Convert to Gas	O2 Reticulation – Central	O2 Reticulation – Spaces	Air Interim	Air Permanent	Expected Completion
Northland	G	✓	✓	✓	✓		WIP	May 2022
Waitemata	G	✓	✓	✓	✓	✓	✓*	Completed
Counties Manukau	G	✓	✓	✓	✓		WIP	April 2022
Lakes	G	✓	✓				✓*	Completed
Bay of Plenty	G		✓				WIP	June 2022
Tairawhiti	G		✓	✓	✓		✓*	May 2022
Hawkes Bay	G	✓	✓		✓		✓*	April 2022
Taranaki	G						✓	Completed
Mid Central	A	WIP	WIP	✓	✓		✓*	September 2022
Hutt Valley	A	WIP	WIP				✓	September 2022
Capital and Coast	G	✓		✓	✓	✓	✓*	Completed
Canterbury	G			✓	✓		✓	Completed

Key
✓ - completed
✓* completed with close-out items
WIP – work in progress
Sched – work is scheduled, but yet to start

Status
Green – on track
Amber – immediate issue/future risk that may affect the timeline. Mitigation measures are in place
Red – issue /risk that will affect delivery. Governance support is required.

Work completed but not shown:
- Supply chain optimisation (oxygen manufacture, network bulk storage and distribution)
- Emergency supply chain measures (supply of portable oxygen bulk storage, supplier emergency protocols)

Document 17

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Update on disability COVID-19 outbreak response

Date due to MO:	7 April 2022	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	20220610
To:	Hon Carmel Sepuloni, Minister for Disability Issues		
Copy to:	Hon Andrew Little – Minister of Health Hon Chris Hipkins – Minister for COVID-19 Response Hon Dr Ayesha Verrall – Associate Minister of Health and for COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
Amanda Smith	Chief Advisor, Disability	S9(2)(a)
Adri Isbister	Deputy Director-General, Disability	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Document 17

Update on disability COVID-19 outbreak response

Security level:	IN CONFIDENCE	**Date:**	6 April 2022
To:	Hon Carmel Sepuloni, Minister for Disability Issues		

Purpose of report

1. This report updates you on COVID-19-related issues for the disabled community and the ongoing COVID-19 health response. It also incorporates other information and responses to questions that your Office has requested to be included in this briefing.

2. The Ministry of Health's COVID-19 Response Directorate, Disability Directorate and Care in the Community team, the Department of the Prime Minister and Cabinet's COVID-19 Group and ACC have contributed to this update. This report discloses all relevant information.

Summary

3. Interagency work continues to ensure that disabled people and their families, whānau and carers who are impacted by the COVID-19 outbreak have the information, access to testing and continuity of care that they need. An update of progress is outlined in this briefing.

Recommendations

We recommend you:

a) **Note** this update.

b) **Note** the frequency of these update briefings will now be monthly as a weekly A3 tracker is now being provided to you.

Adri Isbister
Deputy Director-General
Disability
Date: 6/4/22

Hon Carmel Sepuloni
Minister for Disability Issues
Date:

Document 17

Update on disability COVID-19 outbreak response

Background

1. You have asked the Ministry of Health (the Ministry) to provide you and the Health Ministers with regular update briefings in addition to a weekly A3 progress tracker table of work underway to support the disabled community through the Omicron outbreak.

2. This briefing provides updates of progress since the 24 March 2022 update briefing [HR20220453]. It incorporates responses to questions your Office raised from the last briefing and includes the requested information about the new A3 disability COVID-19 tracker table.

Progress updates

Communication with and support for Home and Community Support Services (HCSS) providers and disabled people's organisations (DPOs)

3. Weekly meetings have now been established with HCSS providers, DPOs and funders (ACC, DHBs and the Ministry) to help work through current and emerging issues related to the continuity of HCSS services.

4. At the 30 March meeting, provider organisations indicated that the pressure of COVID-19 cases is easing off in Auckland but moving further south, with high numbers of cases in the Waikato, Wellington, Christchurch, and Dunedin. Providers now feel better prepared for managing COVID-19 and considered that staff seem to be more comfortable with working and providing care in the current environment.

5. The DPO representatives still had several concerns about the stress caused by the uncertainty of potential disruption to homecare support services. For many people, it is distressing to not know if a regular carer will be able to provide care or whether a stranger will be coming into their home who may not be fully trained and able to provide their usual level of support, or even worse if a replacement caregiver is not able to be found.

6. Providers and funders are working together to address the issues raised and minimise the level of stress felt by the community. Actions include clear communication, in appropriate formats and languages, for disabled people and their whānau.

7. The Ministry also meet with its Te Ao Marama advisory group on 28 March to discuss ongoing service continuity issues. This group includes Māori that work within the disability sector as well as tāngata whaikaha Māori, whānau of tāngata whaikaha Māori, and experts on Māori cultural matters. Ministry staff from the Disability Directorate and COVID-19 Care in the Community team updated the group on progress on supporting disabled people through the COVID-19 outbreak.

Care in the Community

Support through DPOs

8. A Care in the Community proposal, based on a similar COVID-19 vaccination initiative, has been completed and is currently going through the approval process to allocate a pool of $2million that disability organisations and disability providers can use to:

   - communicate and support disabled people in their sector through the care in the community journey
   - provide pre-isolation care packages (including food and essentials) to disabled people in their sector, to assist preparing to isolate because of COVID-19.

9. It is anticipated that funding will be available before the end of April 2022.

CIC metrics

10. The disability self-identification question went 'live' on the National Contact Tracing System (NCTS) on 22 March 2022. This means a 'disability flag' is raised on the person's record, prompting the care coordination hub to prioritise that person for an assessment. In the next release on 6 April 2022, this flag will display on the dashboards in the COVID-19 Clinical Care Module (CCCM) and be filterable. Analysis will be available in the future to show if the wait time for an assessment is reduced for those with a disability flag.

11. Work continues to join three existing databases with information for people who are receiving disability support services to the COVID-19 Care in the Community system to automatically connect if a person with a disability tests positive for COVID-19. This will help provide metrics to measure outcomes for disabled people over the coming months.

Care coordination hubs

12. Work is progressing well to establish a DHB Disability Lead group to connect existing resources across the many care coordination hubs, DHBs and within the Ministry of Health. This group will provide a mechanism for information transfer and shared learning across the health sector. It will also provide a means of building disability knowledge and capacity within the hubs and provide an opportunity for hubs to provide feedback on national level issues and the concerns from disabled people.

Access to COVID-19 testing

13. The Ministry has been working to ensure that the disability community is aware of the system that is now in place for accessing rapid antigen tests (RATs) and for supervised COVID-19 testing, including the in-home option.

14. The following new initiatives are also being implemented that will support disabled people to access and use RATs:

   - If people are unable to leave their home because they have a significant impairment or are immunocompromised, they can phone 0800 222 478 to be referred to a local provider who will then work with the person to help them to access and use RATs. Information about the 0800-number service will be added to the new online disability information hub.

- A Targeted Rural Service was launched on 30 March that is allowing people, including disabled people, who live in remote rural locations (5% of population) access to RATs. It is for people who live rurally and more than a 20 minutes' drive from a collection site. Information about this service is available on the Ministry of Health's website and will also be on the new online disability information hub once it's up and running.

Mask exemptions

15. Until last week the process in place for people to obtain a mask exemption card was supported by a selection of disabled people's organisations on behalf of the Ministry of Health. As of 1 April, mask exemption cards (now called Face Covering Communication Cards) are being processed through the Health Orders Exemption Team within the Ministry of Health. This arrangement will be in place until a permanent solution is established by the Ministry. The disability sector has been informed about the change through a range of communication mechanisms, including through the regular meetings and online communications.

COVID-19 Protection Framework and associated information

16. The Ministry is continuing to work closely with the Department of the Prime Minister and Cabinet (DPMC) to ensure the Care in the Community/COVID-19 Protection Framework (CPF) phase 3 information is kept up-to-date and is available in alternate formats. Information is made available on the Unite Against COVID-19 (UAC) website and then disseminated and shared via other online platforms, networks, and communication mechanisms.

17. Since the last update, information produced in alternate formats (New Zealand Sign Language, Easy Read, Large Print and audio and Braille) has included:

- Changes to the CPF
- How to get a Rapid Antigen Test (note this is general advice, not specific to disabled community)
- How to upload your Rapid Antigen Test results
- COVID-19 Preparedness Video (picture in picture)
- How to get a PCR test (picture in picture).

18. Information currently with the alternate formats group for translation includes information about:

- How to use the contact tracing form
- The AstraZeneca vaccine (updates)
- The Pfizer vaccine (updates)
- How to do a RATs test (picture in picture)
- Life at Orange (updates)
- Life at Red (updates)
- Long COVID.

19. Other planned alternate format information is soon to be commissioned and includes information on the following topics:

- Information for at-risk communities*
- What happens if my carer gets COVID-19?*
- What happens if I get COVID and require care?*
- Getting a face mask communication card*
- How to manage your COVID-19 symptoms
- Travelling to New Zealand.

20. Note the Ministry of Health is currently drafting some of the above content (indicated with an asterisk*) that, when available, will be provided to DPMC for translation into alternate formats.

One-stop-shop disability information hub

21. In response to the Disability Rights Commissioner's call for a one-stop-shop COVID-19 information hub for the disabled community, DPMC led a workshop on 1 April with relevant agencies to collate disability-specific information relating to COVID-19. An online one-stop-shop disability information hub is to be created that will be hosted through the existing UAC website.

22. The UAC web team is collecting all relevant information from agencies and will be structuring web content around it. It is hoped that a first cut of the website will be available in the week beginning 11 April. The purpose of this new online platform is to ensure the disability community can easily find and access information in one place about the COVID-19 pandemic and the supports and services that are available.

23. The Ministry of Health's Disability Directorate has been supporting DPMC and the Office for Disability Issues with the development of this online hub. Work to-date has involved identifying any information gaps and developing appropriate material to fill those gaps. This week content for guidance for disabled people about 'what happens if I get COVID-19' and 'what happens if my caregiver gets COVID-19' has been completed. This content will then be converted into accessible formats and shared on the new hub.

Disability Line

24. Whakarongorau Aotearoa offers a non-clinical dedicated Disability Line that provides COVID-19 advice and support. Any callers who require additional health/clinical support are transferred to its Healthline team.

25. The Ministry is continuing to work with Whakarongorau to expand the knowledge and capacity of their dedicated disability team who are responding to disabled people. This includes providing information about RATs and Care in the Community. From 11 April, the team will also be able to complete forms for people who require a Face Covering Communications Card who cannot use the online form.

26. Whakarongorau is not yet able to provide usage data or user feedback about this service as it is still relatively new, with an expanding scope of available information. It is likely that they will begin to capture this information over the coming weeks.

ACC update

27. ACC continues to hold weekly meetings both externally with its homecare providers and internally with senior and operational leaders to maintain oversight of the impact of COVID-19 on disabled communities. The latter forum is due to be reduced to fortnightly as issues appear to be under control.

28. ACC has now conducted 198 Welfare Checks with disabled clients to ensure they felt safe and well during this COVID-19 pandemic and to ask if their packages of care had been impacted. The feedback was positive with 62% reporting they had no change to their homecare supports and they felt safe. Only 1% reported that they required some assistance. ACC clients that were unable to be contacted, as well as those with assigned Recovery Team Members, received either a text message or an email to contact ACC should they have any issues.

29. ACC has representation at the various collaborative forums including at:

- regular Disability Community Information workshops led by DPMC to build one source of COVID-19 response information
- weekly HCSS meetings that the Ministry facilitates
- monthly cross-funder HCSS quality oversight meetings which ensure collaborative management of any quality issues in the home and community support sector.

30. ACC is also committed to continuous improvement and has undertaken a review of the services provided to disabled people to ensure it has the right supports and services to meet the needs of our disabled clients. This will include and not limited to asking the following:

- Do they feel ACC understands their needs?
- Do we have the right knowledge and capabilities within our Recovery team members to understand the needs of people with disabilities (injury or non-injury)?
- Are there opportunities for improvements ACC could make to the claims management model to support people with disabilities?

Update on IMM – COVID-related responses

31. On 30 March, the Ministry responded to questions about its COVID-19 response for disabled people as part of the Independent Monitoring Mechanism (IMM) domestic forum's process in examining the impact of New Zealand's COVID-19 response for the disability community. The Ministry's responses appeared to be well received. Responses covered many of the areas outlined in our updates to you, such as the ongoing need for data and monitoring, our work to support and communicate with HCSS providers, DPOs, and disabled people, and work to make information available in alternate formats.

A3 weekly disability COVID-19 tracker

32. A weekly A3 tracker table for Ministers has been developed as a summary of a range of activities across government agencies on work underway to support disabled people and their whānau and carers through the COVID-19 outbreak. It is a concise top-level progress update. The tracker is being coordinated by the Ministry of Health and includes work being undertaken by the Ministries of Health, Education and Social Development,

ACC, DPMC and the Office for Disability Issues. You were provided with the first version of the tracker on 1 April.

Next steps

33. The Ministry of Health will continue to provide the A3 tracker and written updates, as and when requested.

ENDS.

Document 18

MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Options for improving respiratory protection against aerosolised viral particles for vulnerable and priority populations

Date due to MO:	22 April 2022	**Action required by:**	29 April 2022
Security level:	IN CONFIDENCE	**Health Report number:**	20220682
To:	Hon Chris Hipkins, Minister for COVID-19 Response Hon Dr Ayesha Verrall, Associate Minister for COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
Stephen Glover	Group Manager, COVID-19 Policy	S9(2)(a)
Maree Roberts	DDG, System Strategy & Policy	S9(2)(a)

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Document 18

Options for improving respiratory protection against aerosolised viral particles for vulnerable and priority populations

Security level:	IN CONFIDENCE	**Date:**	13 April 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response Hon Dr Ayesha Verrall, Associate Minister for COVID-19 Response		

Purpose of report

1. This report provides advice on options to provide vulnerable and priority populations with increased respiratory protection, in order to reduce the risk of transmission of COVID-19 to these groups.

2. The measures outlined in the report form part of the Ministry of Health's plan for managing New Zealand's health and disability system over winter of 2022.

Summary

3. Winter 2022 will be a challenging time for the health system, and for individuals and communities who are particularly vulnerable to COVID-19.

4. As part of our preparation for the winter, the Ministry of Health has explored options for providing masks or particulate respirators to clinically vulnerable individuals and priority populations, in order to improve their respiratory protection and reduce the harm of COVID-19.

5. The Ministry assessed three specific options:

   a. **Option 1** – P2/N95 particulate respirators

   b. **Option 2** – alternative particulate respirators

   c. **Option 3** – three-ply ASTM Level 2/Type IIR ear loop medical masks

6. Of these options, the provision of Level 2 ear loop medical masks (**Option 3**) is recommended because while these masks may be less protective on an individual basis than a correctly fitted particulate respirator, the Ministry considers it likely that a familiar, simple to use option will be more effective at a population level.

7. Particulate respirators have several useability issues, including that:

   a. they are often uncomfortable for users to wear for extended periods of time, which may reduce the likelihood of them being used correctly – and therefore their effectiveness at reducing aerosol transmission of COVID-19;

b. they can cause facial and skin irritation including damage to the skin and swelling to the face; and

c. particulate respirators increase the work of breathing more than medical masks and could have the additional risk of further compromising the respiratory capability of those who have respiratory or cardiac vulnerabilities.

8. Nonetheless, given the potentially increased respiratory protection for certain individuals, it is recommended that a smaller number of P2/N95 particulate respirators are provided to health providers from existing stock held by the Ministry of Health as soon as practicable, for use by the most clinically vulnerable patients (but potentially not those with respiratory/cardiac compromise).

9. The expected cost of providing medical masks through this initiative is $18.8m through to 30 September 2022.

10. To support the provision of medical masks and respirators, the Ministry has developed criteria for determining who is a clinically vulnerable person. Should Ministers approve one of the options in this report, masks or respirators would be distributed via existing channels to both clinically vulnerable people and priority populations.

11. There are two complementary measures which the Ministry will undertake alongside provision of masks or respirators to clinically vulnerable people and priority populations:

a. clear and culturally appropriate messaging over winter 2022 to reinforce fundamental infection prevention and control procedures, such as staying home while sick, wearing a mask and hand hygiene; and

b. promoting simple methods for increasing the effectiveness of medical masks by improving the fit, which include double masking or the use of toggles, clips or knots to shorten the ear loops.

12. Clinically vulnerable people and priority populations will be further supported through the use of oral anti-viral COVID-19 treatments. Pharmac has recently approved access criteria for these treatments which prioritise patients who are immunocompromised or have multiple risk factors, including certain specified conditions range of specified conditions, being over 65 years of age or being of Māori or Pasifika descent.

Recommendations

I recommend you:

a)	**Note** that as part of its preparation for winter 2022, the Ministry of Health has undertaken an assessment of options to improve respiratory protection for clinically vulnerable people and priority populations.	**Noted**
b)	**Agree** to the provision of Level 2 ear loop medical masks to clinically vulnerable people and priority populations at an estimated cost of $18.8m to 30 September 2022.	**Yes/No**
c)	**Agree** to providing a smaller number of P2/N95 particulate respirators to health providers from existing stock held by the Ministry of Health as soon as practicable, for use by the most clinically vulnerable patients.	**Yes/No**

d) **Note** that further work is required to clarify the operational guidance and preparation for the use of P2/N95 particulate respirators among those who are clinically vulnerable. This work will be completed by late April 2022. **Noted**

e) **Note** that the Ministry has developed a definition of clinically vulnerable people, which is consistent with definitions adopted by comparable international jurisdictions, such the United Kingdom and Canada. **Noted**

f) **Note** that should Ministers agree to provide Level 2/Type IIR ear loop medical masks, they would be distributed to clinically vulnerable individuals and priority populations through established channels used to distribute rapid antigen test kits and masks. **Noted**

g) **Note** that the Ministry will also undertake two complementary measures to support and realise the benefits of providing masks: **Noted**

   i. providing clear and culturally appropriate messaging over winter 2022 to reinforce fundamental infection prevention and control procedures, such as staying home while sick, wearing a mask and hand washing; and

   ii. promoting simple methods for improving the effectiveness of medical masks by improving the fit, such as double masks or using clips to shorten the ear loops.

h) **Note** that clinically vulnerable individuals and priority populations will be further supported through the use of oral anti-viral COVID-19 treatments, with access criteria for these treatments having been recently approved by Pharmac. **Noted**

Dr Ashley Bloomfield
Director-General of Health
Date: 13 April 2022

Hon Chris Hipkins
Minister for COVID-19 Response
Date:

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

Options for improving respiratory protection against aerosolised viral particles for clinically vulnerable and priority populations

Background and context

The winter of 2022 will be challenging for the health and disability system and for vulnerable New Zealanders

13. Winter is always a challenging time for the health system. Winter 2022 will be especially challenging due to a long tail of COVID-19 cases, and in time further waves of cases.

14. COVID-19 vaccines have been effective at reducing serious illness and hospitalisation, but this will wane over time.

15. We will be dealing with other illnesses that require a health system response using the same resources we have used to manage COVID-19. As our borders open, illnesses such as influenza and Respiratory Syncytial Virus (RSV), will be reintroduced into our communities.

16. We will be managing this in the context of a health workforce that has been under pressure for a long time, and a diminishing social licence for some of the public health measures we have used over the last two years.

The Ministry of Health is preparing for the winter

17. The Ministry of Health (the Ministry) is preparing a winter plan to address this issue, and operational planning is already underway. Our focus remains on minimising serious illness and death, but the way in which we do that will need to change once again.

18. The proposals of this briefing form one element of those plans. The wider plans will be the subject of separate briefings.

We need to continue to proactively learn about and respond to SARS-CoV-2 to improve outcomes for New Zealanders

19. Over the course of the pandemic there has been a shift in understanding about the mode of transmission of SARS-CoV-2, with an increasing recognition of the role that aerosol transmission plays in the spread of the virus. It is now widely accepted that SARS-CoV-2 can also be transmitted via infectious aerosols, and that this risk is increased in confined, poorly ventilated indoor spaces.

20. As we head into winter and with the risk of new variants emerging, it is important that we remain agile, proactively respond to the limited available evidence as it emerges, and progressively strengthen our risk mitigations as part of a precautionary approach. This is particularly pertinent within the context of our Omicron strategy.

Options for improving respiratory protection for clinically vulnerable and at-risk populations

The Ministry has explored options for reducing serious illness and death among clinically vulnerable and priority populations by improving respiratory protection for those individuals

21. As part of our precautionary approach, it would be possible to provide a higher level of respiratory protection to those who are clinically vulnerable to respiratory viruses or members of priority populations than is offered by the medical masks or other face coverings currently used.

22. The purpose of providing respiratory protective equipment (RPE) would be two-fold:

    a. reducing the real risk of serious illness, poor health outcomes and death for clinically vulnerable and priority populations by providing improved respiratory protection; and

    b. providing greater assurance to clinically vulnerable people, to allow them to participate in society more confidently.

There are three feasible options for providing respiratory protective equipment free of charge to improve respiratory protection for vulnerable and priority populations

23. **Option 1: P2/N95 particulate respirators**, such as 3M 8210, 3M 9210 or Drager 1720C particular respirators, which are similar to those used by the non-healthcare workforce;

24. **Option 2: Alternative particulate respirators,** such as those which are designed to a KN95 or KF94 standard; and

25. **Option 3: Three-ply ASTM Level 2/Type IIR ear loop medical masks**, which are currently provided to patients and visitors in hospital, primary care and certain other settings and priority populations through direct distribution from the Ministry.

26. It is also possible to adopt a combination of these options, with different kinds of masks or respirators being provided to different groups.

The Ministry has assessed each of these three options against several key considerations

27. These factors are:

    a. efficacy of the RPE for an individual, when used correctly;

    b. real world efficacy of the RPE at a population level; and

    c. supply and cost considerations.

28. A summary of this assessment is at **Attachment 1**, with a more detailed assessment set out below.

<u>Efficacy of the RPE for an individual, when used correctly</u>

29. When used correctly, including being fitted tightly to an individual's face, P2/N95 particulate respirators (**Option 1**) are likely to provide the greatest level of respiratory protection of the three options considered. It is estimated that the fitted filtration

efficiency of such a respirator is up to 98%, compared with around 38.5% for a Level 2/Type IIR ear loop medical mask (**Option 3**).

30. Alternative particulate respirators (**Option 2**) may provide close to the level of respiratory protection for an individual which could be achieved with a P2/N95 particulate respirator. However, should Option 2 be pursued, a further review of the test certificate, regulatory requirements and verification for authenticity would be prudent.

Real world efficacy of the RPE, at a population level

31. At a population level, it is likely that the actual efficacy of these different kinds of RPE in improving respiratory protection would be markedly different, with Level 2/Type ear loop medical masks (**Option 3**) likely to be more effective than particulate respirators in reducing transmission of COVID-19 (and other respiratory illnesses), serious illness and death.

32. This is because of several significant disadvantages with particulate respirators:

a. **discomfort may reduce correct use**: particulate respirators – whether P2/N95 or an alternative – are often uncomfortable for a person to wear, particularly for extended periods of time. This is likely to increase the incidence of individuals removing their masks or wearing them in a way that it ineffective, such as covering their mouth but not their nostrils);

b. **particulate respirators perform best when they fit well:** this means that a person wearing a loosely fitted P2/N95 particulate respirator may have a lower level of respiratory protection than a person wearing a well-fitting Level 2 ear loop medical mask; and

c. **a possible perception by some individuals that they are "protected" by a higher grade of mask may increase complacency and reduce compliance with fundamental infection prevention and control practices**: the benefits of increased respiratory protection may be offset by reduced compliance with basic practices, such as staying home when sick, physical distancing or hand washing.

Supply and cost considerations – P2/N95 particulate respirators (**Option 1**)

33. Global supply of P2/N95 particulate respirators remains constrained for a variety of reasons, including the increasing incidence of COVID-19 cases, trade and export measures internationally and the reduction in emergency use authorisation initiatives.

34. The Ministry currently holds a total available supply of 6,247,680 P2/N95 particulate respirators (3M 8210, 3M 9210 & Drager 1720C), for this initiative. There is the potential to utilise the previous national reserve supply however, this is contingent on further review of the retested documentation and quality of held stock. If available and required for use post examination, this would add a further 9 million P2 particulate respirators to the current available stock.

35. The following supply model has been created on the assumption that the clinically vulnerable population requirements equates to 800,000 people with an average weekly use of 3 comparable P2/N95 particulate respirators, and at an average cost of $2.00 per particulate respirator (mask + freight) (**Table 1**).

36. Note that this supply model is on top of the current utilisation and budget estimations for the healthcare and disability workers currently accessing and utilising P2/N95 particulate respirators.

*Table 1: P2/N95 particulate respirators (**Option 1**) for use by clinically vulnerable people and cost assumptions*

Clinically vulnerable additional respiratory comparable P2/N95 supply requirements (approximate)	P2/N95 Per week requirements (at 3 particulate respirators per week)	P2/N95 Cost per week (average at $2 per unit purchased at national volume)	Total volume of respirators required to support initiative until 30 September 2022	Impact of decision on budget (from 14 April 2022 to 30 September 2022)
800,000	2.4m	$4.8m	57.6m	$115.2m

Supply and cost considerations – alternative particulate respirators (**Option 2**)

37. The Ministry has the opportunity to source alternate particulate respirators in the form of a Chines KN95, Korean KF94 or European FFP2, for this initiative. These differ by ≤1% bacterial filtration efficacy compared with P2/N95 particulate respirators. Again, this is contingent on further review of the test certificate, regulatory requirements and verification for authenticity.

38. The following supply model has been created on the assumption that the clinically vulnerable population requirements equates to 800,000 people with an average weekly use of 3 comparable alternate particulate respirators, and at an average cost of $0.80 per particulate respirator (mask + freight) (**Table 2**).

39. Note that this supply model is new and based on assumptions and indicative national volume sourced costs.

*Table 2: Alternate particulate respirators (**Option 2**) for use by clinically vulnerable people and cost assumptions*

Clinically vulnerable additional respiratory comparable P2/N95 supply requirements (approximate)	Alternate particulate respirators Per week requirements (at 3 particulate respirators per week)	Alternate particulate respirators Cost per week (average at $0.80 per unit purchased at national volume)	Total volume of respirators required to support initiative until 30 September 2022	Impact of decision on budget (from 14 April 2022 to 30 September 2022)
800,000	2.4m	$1.92m	57.6m	$46.08m

Supply and cost considerations – alternative particulate respirators (**Option 3**)

40. The Ministry has the opportunity to consider the use of 3 ply ASTM Level 2/Type IIR ear loop medical mask to provide clinically vulnerable people with sufficient specification masks.

41. The following supply model has been created on the assumption that the clinically vulnerable population requirements equates to 800,000 people with an average weekly use of seven 3 ply ASTM Level 2/Type IIR ear loop medical mask and at an average cost of $0.14 per mask (mask + freight) (**Table 3**).

42. Note the Ministry of Health has provided over 10 million 3 ply ASTM Level 2/Type IIR ear loop medical masks to priority populations since 17 August 2021.

*Table 3: 3 ply ASTM Level 2/Type IIR medical masks (**Option 3**) for use by clinically vulnerable people and cost assumptions*

Clinically vulnerable additional respiratory comparable Medical/Procedure mask supply requirements (approximate)	Medical/Procedure mask Per week requirements (at 7 masks per week)	Medical/Procedure mask Cost per week (average at $0.14 per unit purchased at national volume)	Total volume of medical masks required to support initiative until 30 September 2022	Impact of decision on budget (from 14 April 2022 to 30 September 2022)
800,000	5.6m	$0.78m	134.4m	$18.8m

Based on this assessment, it is recommended that Ministers approve Option 3

43. While on an individual basis, particulate respirators may provide greater respiratory protection for an individual and may give some users greater confidence to participate more fully in society, Level 2/Type IIR ear loop medical masks remain the most suitable option for use by the public.

44. These masks are easy to use, familiar, inexpensive, more comfortable than particulate respirators and effective.

45. Option 3 will build on the Government's existing approach, with the Ministry having already provided over 10 million Level 2/Type IIR ear loop medical masks to priority populations since 17 August 2021.

However, in the case of individuals who are clinically vulnerable, there is a strong case to supply smaller numbers of P2/N95 particulate respirators

46. It is also recommended that a smaller number of P2/N95 particulate respirators be supplied to health providers from existing stock held by the Ministry of Health as soon as practicable, for use by the most clinically vulnerable patients, but potentially not those with respiratory/cardiac compromise.

47. This measure acknowledges that in certain cases, there may significant benefits to for high risk individuals from using particulate respirators. This might include, for example, an immunosuppressed patient who is regularly required to visit a hospital for treatment.

48. To enable this measure to be effective, the Ministry of Health will work to clarify the operational IPC guidance for the use of comparable P2/N95 particulate respirators and will support local health providers with information to provide to at risk patients. This work will be complete by late April 2022, alongside an active infection prevention and control national communications programme.

The Ministry has developed criteria for determining eligibility to receive publicly funded masks or respirators based on clinical vulnerability to COVID-19, which are similar to definitions adopted in comparable international jurisdictions

49. In countries like the United Kingdom, France, United States and Canada, there have been various definitions of "extremely high risk" patients, including but not limited to the term "clinically extremely vulnerable". Given New Zealand's high vaccination rates broadly, we have settled on the term "clinically vulnerable" only for this initiative.

50. People defined as clinically extremely vulnerable are at very high risk of severe illness from COVID-19. Internationally, there are two ways in which people have been identified as clinically vulnerable:

    a. they have one or more of the conditions listed below; or

    b. their hospital clinician or general practitioner has confirmed in writing that based on their clinical judgement, they deem a person to be at higher risk of serious illness if they catch the virus or if they have not received vaccination for the virus due to a serious medical condition.

51. Adults and young persons with the following conditions would be deemed clinically vulnerable for the purposes of additional respiratory protective equipment (publicly funded and provided mask/particulate respirator):

    a. Solid organ transplant recipients

    b. Those with specific cancers:

        i. People with cancer who are undergoing active chemotherapy

        ii. People with lung cancer who are undergoing radical radiotherapy

        iii. People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment

        iv. People having immunotherapy or other continuing antibody treatments for cancer

        v. People having other targeted cancer treatments that can affect the immune system, such as protein kinase inhibitors or poly adenosine diphosphate-ribose polymerase (PARP) inhibitors

    c. People who have had bone marrow or stem cell transplants in the last 6 months or who are still taking immunosuppression drugs

    d. Those with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary disease (COPD)

    e. Those with rare diseases that significantly increase the risk of infections (such as severe combined immunodeficiency (SCID), homozygous sickle cell disease)

    f. Those on immunosuppression therapies sufficient to significantly increase risk of infection

    g. Adults with Down's syndrome

    h. Adults on dialysis or with chronic kidney disease (stage 5)

    i. People who are pregnant with significant heart disease, congenital or acquired

j. Other people who have also been classed as clinically vulnerable, based on clinical judgement and an assessment of their needs. GPs and hospital clinicians have been provided with guidance to support these decisions.

52. There remains a smaller number of people who, in spite of COVID-19 vaccination, are at higher risk of serious illness from COVID-19. This is due to a weakened immune system (immunosuppressed) or specific other medical conditions and requires enhanced protections such as those offered by antibody and antiviral treatments, additional medical supports and potentially other non-clinical interventions such as masking.

53. Immunosuppression means a person has a weakened immune system due to a particular health condition or because they are on medication or treatment that is suppressing their immune system. People who are immunosuppressed, or have specific other medical conditions, may have a reduced ability to fight infections and other diseases, including COVID-19.

54. Most people with immunosuppression will be under the care of a hospital specialist and will usually have been identified in one of 2 ways:

a. Eligibility for a publicly funded clinically administered Flu vaccination or early COVID-19 vaccine booster and

b. Eligibility for new treatments for COVID-19.

55. For the purposes of this initiative, priority populations are considered to be:

a. Māori;

b. Pasifika;

c. People aged 65 or over; and

d. People with disability.

Masks and respirators would be distributed through established channels already used to distribute rapid antigen test kits and medical masks

56. This would include:

a. Māori and Pacific health providers who assess their patients are clinically vulnerable;

b. Māori and Pacific health providers who determine their patients reflect a priority population in need;

c. community assessment teams who determine their patients as clinically vulnerable;

d. general practice and urgent care clinics who assess their patients as clinically vulnerable or who are representative of a priority population;

e. the Maori Provider Distribution Channel (MPDC) which has a reach of over 1000 community partners serving vulnerable and marginalised communities; and

f. Māori and Pacific support services that are not currently supported by the Ministry of Social Development funding to access medical masks.

g. funded disability service providers, including for disabled people who employ their own support workers through individualised funding or personal budgets; and

h. distribution through assisted pathways, like the RAT home delivery and rural delivery services.

The Ministry will also undertake two complementary measures to support and realise the benefits of providing masks to clinically vulnerable people and priority populations

57. Supporting measures will comprise:

    a. clear and culturally appropriate communications leading into and throughout the winter of 2022 to reinforce the importance of fundamental infection prevention and control practices. This includes, but is not limited to, staying at home while sick, using masks, hand washing, obtaining a test for COVID-19 and reporting test results;

    b. promoting simple methods for improving the effectiveness of medical masks by improving the fit. This would include:

        i. double masking, that is, wearing a medical mask underneath a tighter fitting cloth mask; and

        ii. the use of clips, mask braces, fasteners, and/or toggles, which attach to the ear loops and tighten the mask behind the ears or head.

Access to oral anti-viral COVID-19 treatments

58. Clinically vulnerable people and priority populations will also benefit from access to oral anti-viral COVID-19 treatments.

59. Pharmac has recently approved access criteria for these treatments which prioritise patients who are:

    a. immunocompromised; or

    b. have five or more risk factors, including certain specified conditions range of specified conditions, being over 65 years of age or of Māori or Pasifika descent.

60. These treatments will work alongside public health measures to help reduce serious illness and death among clinically vulnerable people and priority populations.

Te Tiriti analysis

61. Māori are one of the priority populations considered for this initiative. The distribution of Level 2/Type IIR ear loop medical masks to Māori is proposed in recognition of the greater risk faced by Māori due to COVID-19.

62. As with the distribution of other medical consumables to Māori (such as testing kits), the Ministry is seeking to partner with Māori health organisations and other support services as a key mechanism for distribution of masks and respirators.

63. Māori health organisations will also play a role in determining which clinically vulnerable Māori may benefit from the use of P2/N95 particulate respirators.

64. This role allows Māori to exercise rangatiratanga in the way in which RPE is distributed to Māori, and who among that community should receive different kinds of RPE.

Equity

Usability and fit of the masks

65. A key consideration for this work has been the suitability of different kinds of respirators and masks for a wide variety of users, including elderly or disabled users and users of different ethnic backgrounds.

66. Current evidence suggests that the *fit* of a mask is an important factor with respect to the level of respiratory protection they provide to the wearer against aerosols. This means that a poorly fitted mask (e.g. with 'gaping' at the sides) provides less respiratory protection to the wearer than a mask that is well-fitted to an individual's face.

67. Given the diversity in facial characteristics across the motu, there is likely to be variation in the quality of fit of masks, and therefore protection provided by these masks.

68. There are limited options available to us to provide clinically vulnerable people with better fitting masks.

69. From the perspective of users, one of the key advantages of Level 2/Type IIR ear loop medical masks is that they can be readily combined with other masks or adjusted through simple inexpensive means such as clips or knots to improve the fit, and that because the masks are so flexible, this is true for all users.

70. The majority of people are adept at using these types of masks and know how to put them on and remove them safely. Nonetheless, there will always remain some people who will have difficulty using any kind of mask or respirator effectively, such as individuals with arthritis that makes it difficult to manipulate the ear loops of a mask, or those with breathing difficulties.

Accessibility of supply

71. In order for the additional masks and respirators to be useful, they must be accessible to clinically vulnerable people and priority populations. This is a particular issue for isolated, rural communities, as well as some individuals with physical disability.

72. For this reason, the Ministry will rely on a wide range of established distribution channels that reach deep into different populations, and which have already been used to distribute masks and Rapid Antigen Test kits.

Preference for other types of RPE

73. Some individuals who are not clinically vulnerable may prefer to use a particulate respirator, notwithstanding the factors which may reduce the effectiveness of these devices and the discomfort of wearing them for extended periods of time.

74. For such individuals, the best option may be to purchase KN95 particulate respirators or comparable models, which are widely available in New Zealand.

Next steps

75. Subject to ministerial approval, the Ministry will immediately progress implementation as part of our preparations for the winter of 2022.

76. We will keep you informed of progress in our regular weekly updates.

ENDS

Attachment 1 – summary of assessment of options for improving respiratory protection for clinically vulnerable people and priority populations

	Option 1 **P2/N95 particulate respirators**	**Option 2** **Alternative particulate respirators**	**Option 3** **Level 2 ear loop medical masks**
Efficacy for an individual	Most effective, if fitted correctly on a user's face	Highly effective, if fitted correctly on a user's face	Moderately effective, but able to be made significantly more effective by improving the fit (eg: with double masking or tightening ear loops)
Efficacy at population level	Effectiveness at a population level is likely to be reduced by the discomfort most users will feel wearing particulate respirators for extended periods. Effectiveness may also be offset due to greater complacency about basic infection and control practices.	Effectiveness at a population level is likely to be reduced by the discomfort most users will feel wearing particulate respirators for extended periods. Effectiveness may also be offset due to greater complacency about basic infection and control practices.	Likely to be most effective at a population level due to greater comfort, ease of use, familiarity and suitability for a wide range of different face shapes
Feasibility of supply	Able to be supplied	Able to be supplied, subject to on further review of the test certificate, regulatory requirements and verification for authenticity	Able to be supplied
Estimated cost	$115.2m	$46.08m	$18.8m

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PHARMAC
TE PĀTAKA WHAIORANGA

MINISTRY OF HEALTH
MANATŪ HAUORA

Joint Briefing

COVID-19 vaccine purchasing and management transition to Pharmac

Date due to MO:	20 April 2022	**Action required by:**	27 April 2022
Security level:	Commercially Sensitive	**Health Report number:**	HR20220639
To:	Hon Chris Hipkins, Minister for COVID-19 Response Hon Andrew Little, Minister of Health		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, System Strategy and Policy	S9(2)(a)
Peter Alsop	Director Engagement and Implementation (Pharmac)	S9(2)(a)

Minister's office to complete:

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

Comment:

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COVID-19 vaccine purchasing and management transition to Pharmac

Security level:	Commercially Sensitive	**Date:**	20 April 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response Hon Andrew Little, Minister of Health		

Purpose of report

1. This paper provides you an update on the preparations to date to implement Cabinet's in-principle decision to transfer COVID-19 vaccine purchasing and management from the Ministry of Health to Pharmac [SWC-21-MIN-0223 refers].

2. We wish to discuss the overall direction of the work to date in preparation for drafting a Cabinet paper for May 2022.

Key Points

3. The Ministry of Health and Pharmac have begun mapping the detailed end-to-end process for COVID-19 vaccine purchasing and management, including identifying key differences with Pharmac's existing purchasing processes.

4. It will be necessary in finalising the details of the transfer to:

   a. align with the wider strategic approach to integrating immunisation programmes to ensure population protection against the full range of vaccine preventable diseases as agreed by Cabinet [SWC-21-MIN-0223 refers];

   b. retain an overarching strategy and outcomes focus to the COVID-19 immunisation programme (including purchasing functions and management), which enables alignment of objectives across settings and the health system;

   c. ensure the immunisation system (including COVID-19 immunisation) is prevention focused, responsive, easily accessible and equitable (including meeting our obligations under te Tiriti o Waitangi);

   d. maintain vaccine portfolio, purchasing and management functions that support the evolving response to COVID-19; and

   e. manage the remaining uncertainty and risk posed by COVID-19 through the transition.

5. We are considering the end-to-end process in more detail to identify any insights that can assist other vaccine programmes. There is significant scope for improvement in how different functions and roles work together to improve the outcomes in each programme and the health system overall.

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Recommendations

a)	**Note** that Cabinet agreed in principle to transfer responsibility for ongoing management and purchase of COVID-19 vaccines from the Ministry of Health to Pharmac from 1 July 2022;	**Yes** / **No**
b)	**Note** that Cabinet invited the Minister of Health to report back to the Social Wellbeing Committee in May 2022, setting out the arrangements for the transfer to Pharmac;	**Yes** / **No**
c)	**Note** that officials have mapped out the high-level approach and end-to-end pathway for COVID-19 vaccine purchasing and management;	**Yes** / **No**
d)	**Note** that officials wish to discuss the high-level approach and end-to-end pathway for COVID-19 vaccine purchasing and management;	**Yes** / **No**
e)	**Note** that we intend to provide a paper in late April for you to report back to Cabinet on 18 May 2022; and	**Yes** / **No**
f)	**Note** this Cabinet paper will confirm the specific roles and responsibilities, and timelines for the operational transfer of functions to Pharmac.	**Yes** / **No**

Hon Chris Hipkins

Minister for COVID-19 Response

...../...../..... 25/4/2022

Hon Andrew Little

Minister of Health

...../...../.....

Maree Roberts

Deputy Director-General

System Strategy and Policy

20/04/2022

Peter Alsop

Director Engagement and Implementation, Pharmac

20/04/2022

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COVID-19 vaccine purchasing and management transition to Pharmac

Background

1. In principle, Cabinet agreed to transfer responsibility for the ongoing management and purchase of COVID-19 vaccines from the Ministry of Health to Pharmac from 1 July 2022 [SWC-21-MIN-0223 refers].

2. The transfer was subject to a report from the Minister of Health in May on the necessary arrangements for this decision [SWC-21-MIN-0223 refers].

3. It was considered appropriate to transfer the functions at this time with:

   a. COVID-19 vaccine supply and development stabilising and a significant proportion (high-level) of the population immunised;

   b. pandemic purchasing moving closer to Pharmac's usual role in vaccine management, including purchase and supply management;

   c. a changing communicable disease landscape as we reconnect with the world while the pandemic continues, and need to focus on a broader range of immunisation needs; and

   d. a focus on broader health and wellbeing outcomes as we emerge from the acute phases of pandemic and maximise opportunities for a newly aligned, cohesive health system to improve equity and health outcomes.

4. The transfer is taking place alongside the Health and Disability System reforms and the Government's response to the Pharmac Review, allowing for greater alignment with the new system while learning from the COVID-19 response.

Progress to date

5. The Ministry of Health, Pharmac, and the Ministry of Foreign Affairs and Trade have been mapping out the current processes and functions, including a high-level view of the pathway and end-to-end process.

6. Work to date has focused on a high-level view of:

   a. the end-to-end pathway of the outcomes-based approach to the COVID-19 immunisation programme;

   b. the overarching functions that support the programme;

   c. the inputs and role that purchasing has across the end-to-end pathway to achieve the desired outcomes; and

   d. an initial scope of where this is likely to differ from Pharmac's usual processes.

7. More detailed work is underway to map the purchasing function, including the processes for identifying needs, assessment of vaccines and purchase options, and portfolio and contract management.

Managing the transfer during the pandemic

8. It is crucial the transfer of COVID-19 vaccine management and purchasing functions maintains the outcomes focused response to COVID-19 and continuing to mitigate its impact on New Zealand and the health system.

9. We will need to ensure that the institutional arrangements for the COVID-19 immunisation programme as a system (including the roles of Pharmac, the Ministry of Health, and the new health agencies) support the objectives of the COVID-19 response.

10. A key component of this is the immediate response related to Reconnecting New Zealand and the reopening of borders. There are health risks associated with this reconnection. COVID-19 vaccine purchasing and management functions will need to continue to support a National Immunisation Programme response effectively.

11. As we transfer functions, it will be critical to maintain our effective response to COVID-19. To ensure a smooth transition:

    a. Cabinet has already agreed that COVID-19 vaccines will continue to be funded separately from the Combined Pharmaceutical Budget; and

    b. Ministers will continue to approve final decisions on purchases [SWC-21-MIN-0223].

12. The Ministry of Health, Pharmac and the Ministry of Foreign Affairs and Trade are building out a timeline for the transfer and likely decision making and purchasing requirements. This includes outlining continuing risks and mitigations to ensure transparency for the COVID-19 immunisation programme.

The COVID-19 immunisation programme – how it's worked do date

13. Immunisation has been a cornerstone of New Zealand's pandemic response to manage the risks of COVID-19.

14. The challenges of COVID-19 meant the response was done differently. Vaccine purchasing and portfolio management, distribution and immunisation management was centralised to support and coordinate New Zealand's pandemic response and ensure agility in responding to emergent need and managing significant uncertainty.

15. The success of the COVID-19 immunisation programme is in part due to alignment across the health system. The programme aligns with an end-to-end pathway from strategy to outcomes, as part of:

    a. a strategic system-wide response to COVID-19 (New Zealand has responded to COVID-19 in a coordinated approach with cross sector and agency programmes aiming to reduce the likelihood and harms of COVID-19); with

b. each programme guided by the same strategy and geared towards achieving the same objectives of reducing the impact of COVID-19.

16. COVID-19 vaccine purchasing and management was part of an outcomes focussed process with:

a. a pathway or end-to-end view of the COVID-19 immunisation programme and as part of the wider COVID-19 Response Strategy;

b. supported by overarching functions and an outcomes approach across each component of the programme; and

c. input from all areas of the programme from strategy through to delivery.

17. An overview of this process is provided in Appendix One.

18. This system-wide joint agency and sector process from strategy to outcome with accountability across all parties:

a. enables alignment of objectives across the programme, ensuring purchasing decisions and management of vaccines are not made in isolation of other programme areas;

b. manages uncertainty and risk across the programme and not just within each function;

c. provides agility and responsiveness to drive change and ensure a balance across priorities for the programme and the other programme/s as part of the system response to COVID-19;

d. confirms priorities, sets expectations and adjusts planning to improve outcomes;

e. allows funding and purchasing decisions to follow strategic intent and adjust to a change in priorities;

f. allows for transparency across the programme/s and joint accountability to achieve outcomes.

Things that need working through due to the new approach

19. We are carefully working through the detailed end-to-end system mapping of the current Ministry of Health process. Similarly, we are mapping out Pharmac's current vaccine purchasing and management processes. System mapping also considers the Ministry of Foreign Affairs and Trade's role in COVID-19 purchasing and management.

20. Mapping has highlighted processes and functions that have contributed to the success of the COVID-19 immunisation programme, including:

a. assessment and decisions on vaccines being considered against wider determinants of health, e.g. the economy in New Zealand's COVID-19 response;

b. decision making and governance at a COVID-19 immunisation programme level and wider COVID-19 Response, e.g. Ministerial and Cabinet oversight across the programme including purchase and management decisions;

c. consistent overarching advisory functions across the immunisation programme, e.g. science and technical support through the COVID-19 Vaccine Technical Advisory Group;

d. context specific management and purchasing strategy, adjusted regularly to manage risk and shift with immunisation programme priorities and the wider COVID-19 response. This includes the vaccine portfolio risk management approach, and additional purchases via suppliers and other jurisdictions and bilateral and multilateral donations; and

e. providing international and regional support to Polynesia and the Pacific, including direct purchasing for countries and secondary donation of vaccines.

21. Many of these functions and processes are already in use by Pharmac (for example, through the COVID-19 therapeutics work programme) or are being considered for the National Immunisation Programme.

The transfer is also occurring during the transition of the current health system

22. The overall outcomes of the immunisation system (including COVID-19 immunisation) are to improve the health outcomes for all New Zealanders, which means that the system is prevention focused, responsive, easily accessible and equitable.

23. The transfer of COVID-19 vaccine purchasing is part of a wider set of changes required to accommodate the responses to the Health and Disability System reforms and Pharmac Review. Therefore, the transfer aligns with the timing of these responses.

24. There is a significant opportunity for the response to the Pharmac Review and Health and Disability System reforms to be informed by the successes and lessons of the COVID-19 immunisation programme.

25. Lessons from the COVID-19 immunisation programme can help improve vaccinations rates across preventable diseases as we transition towards an integrated national immunisations programme consistent with a more integrated health system.

Maintaining outcomes-focussed approach after the transfer

26. The context is already shifting as we look to integrate the immunisation programmes and ensure that the health system responds to our wider intent of reconnecting New Zealand with the world. This reiterates the need:

a. an overarching Immunisation Strategy, connected and aligned functions and an end-to-end view across all immunisation programmes, including COVID-19; and

b. that priorities will need to shift and change to the environment with the overarching National Immunisation Programme to manage risk and achieve outcomes.

27. To maintain an outcomes-focussed approach for the COVID-19 immunisation programme we are looking at the governance and oversight functions, i.e. how agencies will work together while retaining clear accountability lines. These arrangements may influence other approaches to vaccinations as we move towards an integrated immunisation programme.

28. It is expected that, alongside ringfenced funding and Ministerial oversight, clarity on the governance and oversight functions will mean that we are able to:

    a. maintain the outcomes of the COVID-19 response;

    b. support the National Immunisation Programme at this time specifically focused on responding to the impacts from COVID-19;

    c. learn from our COVID-19 response as we consider what next.

Managing risks

29. There are risks associated with managing a transition.

COVID-19 Risks and pandemic environment

30. There continues to be a level of uncertainty and risk for the COVID-19 immunisation programme and our response to COVID-19. Vaccine understanding and use is stabilising, but significant uncertainty remains:

    a. protection wanes over time – fully effective and enduring protection is not yet on the horizon;

    b. access and inequity – improving in New Zealand but inequitable globally;

    c. future variant threat remains;

    d. we do not know what vaccine coverage or frequency may be needed in the long term; and

    e. s 9(2)(b)(ii) [redacted]

31. In transferring vaccine management and purchasing to Pharmac, we must continue to manage ongoing vaccine requirements for COVID-19 and look to support the sustainability of a wider national immunisation programme. This will include further work to develop a clear timeline, expected upcoming decisions, and identify and manage any potential risks for the National Immunisation Programme in 2022.

Alignment Risks

32. To ensure continuity, the transfer of COVID-19 vaccine purchasing and management must align with the Health and Disability System reforms and Pharmac Review. This includes:

    a. maximising the opportunities by the new set of agencies working together in a more cohesive, aligned, pro-equity, people-centred and future focused health system; while

b. minimising the risk of eliminating opportunities for close collaboration with the current National Immunisation Programme or reducing responsiveness to emerging risks or issues through the transfer of functions to Pharmac.

c. meeting our obligations under te Tiriti o Waitangi for Partnership and Kaitiakitanga. This includes a wider partnership with health system entities and Māori, focused on what Māori want from health and immunisation outcomes and prioritising of a National Immunisation Programme.

Next steps

33. The Ministry of Health and Pharmac will progress work on the detailed transition plan and drafting of a Cabinet paper, subject to any feedback on the direction of work to date. This includes engagement with key agencies and stakeholders on the transfer and timelines.

34. The transition plan will ensure that we have consistency and continuity in managing our COVID-19 vaccine portfolio in 2022 and outyears, and allow for the continued close alignment with the National Immunisation Programme and our ongoing COVID-19 response.

35. A draft Cabinet paper will be provided in late April, which will seek approval to the transfer of vaccine management and purchasing to Pharmac; including a transition plan that provides:

    a. overview of the functions and underpinning activities;

    b. roles and responsibilities; including:

        i. the roles that would move to Pharmac

        ii. additional measures, resources and support for Pharmac

        iii. residual roles and where they will be led;

    c. governance and accountability of each function and whole system functioning and connectedness;

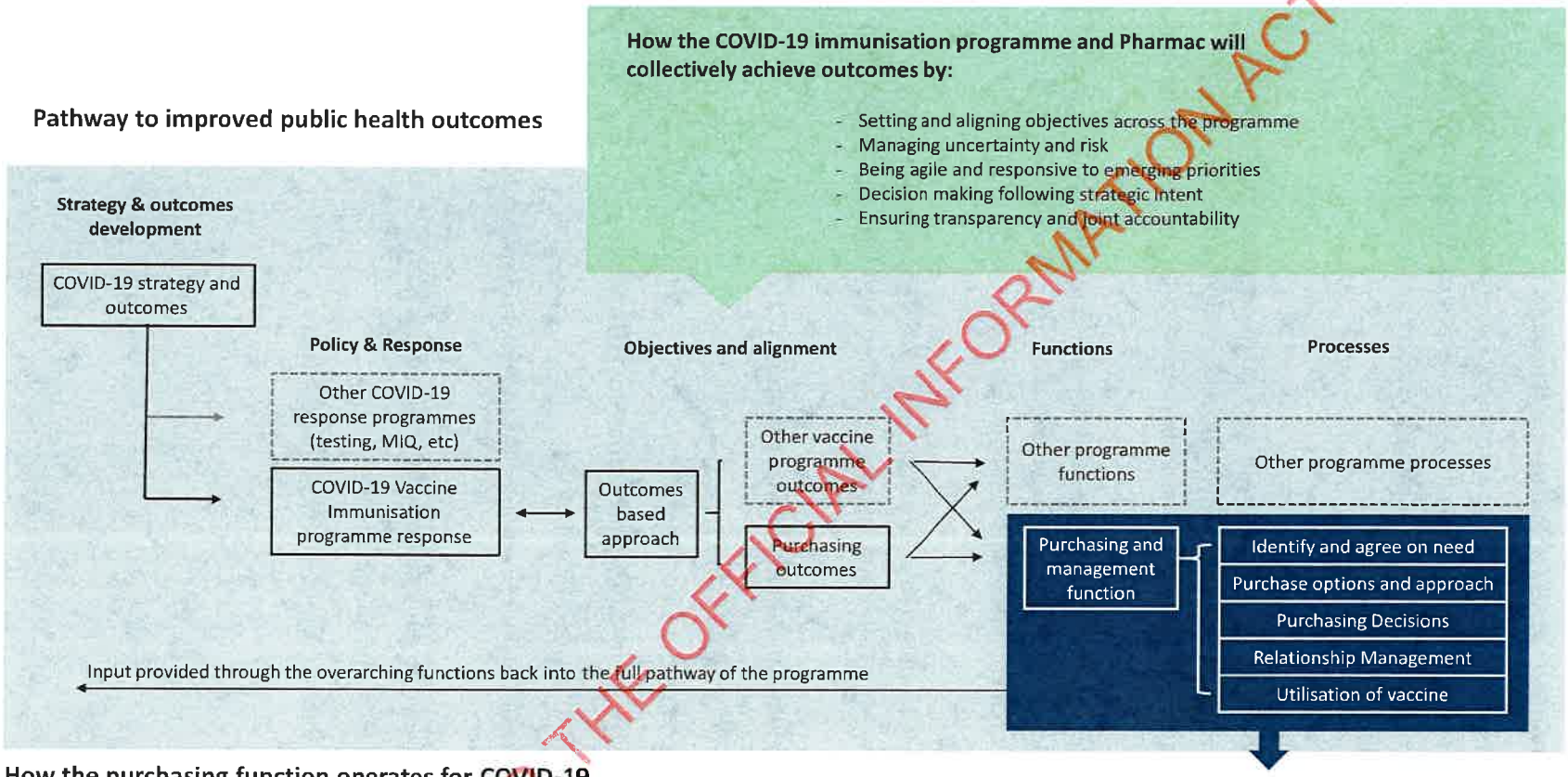
    d. contract, legal implications, and any financial implications; and

    e. any resourcing requirements and timeframes.

36. A timeline for advice to Cabinet is provided in Appendix Two.

ENDS.

Appendix One: COVID-19 vaccine purchasing and management



How the purchasing function operates for COVID-19

	A. Identify and agree on need	B. Purchase options and approach	C. Purchasing Decisions	D. Relationship Management	E. Utilisation vaccine
Description	Identify and agree on best approach to support strategy and outcomes of the programme	Options / ways to meet need are assessed and agreed	Assessment process on the best option/s for programme outcomes	Process to manage suppliers and supply options for programme consideration	Deciding on how to use the vaccines within the portfolio to achieve the outcome
COVID-19 Approach	Identified vaccine needs and portfolio approach as most effective way to manage significant risk	Identified best option to build risk based portfolio (advance purchase agreements, amendments, bilateral arrangements and COVAX Facility)	Assessing individual vaccine candidates and portfolio need to manage risk and best support immunisation programme	Delivery timing and supply to support programme outcomes and mitigate risk	Domestic use, maintaining access to manage risk, regional support and donation to maximise utilisation of existing vaccine supply

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Appendix Two: Timeline

Week	Scope & development of advice	Cabinet	Transfer
28 March - 1 April	Engagement with agencies		
4 – 8 April	Stakeholder feedback		
11 – 15 April	Advice confirmed by agencies		
18-22 April			
25-29 April	Scope and objectives confirmed by Ministers	Ministerial Consultation on draft Cabinet	
2-6 May			
9-13 May		Lodgement of Cabinet Ppaer	Engagement with Bell Gully on legal / contract requirements
16 – 20 May		SWC	Engagement with suppliers on intent to transfer
23 – 27 May		Cabinet	Formalised transition timeline agreed
June			Transition of functions begins
July			1 July operational handover of vaccine purchasing

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MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing

Review of pre-departure testing and vaccination requirements for arrivals to New Zealand

Date due to MO:	27 April 2022	**Action required by:**	4 May 2022
Security level:	IN CONFIDENCE	**Health Report number:**	20220554
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Contact for telephone discussion

Name	Position	Telephone
Dr Ashley Bloomfield	Director-General of Health	S9(2)(a)
Maree Roberts	Deputy Director-General, System Strategy and Policy	

Minister's office to complete:

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

Comment:

Document 20

Review of pre-departure testing and vaccination requirements for arrivals to New Zealand

Security level:	IN CONFIDENCE	**Date:**	27 April 2022
To:	Hon Chris Hipkins, Minister for COVID-19 Response		

Purpose of report

1. This briefing provides advice on pre-departure testing and vaccination requirements for arrivals to New Zealand, in accordance with the requirement in the COVID-19 Public Health Response Act (2020) to keep Orders under review.

2. S9(2)(f)(iv) [redacted]

Summary

3. New Zealand's border restrictions have been incrementally reduced over the course of this year in response to the changing risk of COVID-19 and in accordance with the Reconnecting New Zealanders with the World Programme. From a public health perspective, the primary pre-travel restrictions remaining on passengers entering New Zealand by air are the requirement to have a pre-departure test and the requirement for non-New Zealand Citizens to be vaccinated.

4. s 9(2)(g)(i) [redacted]

5. New Zealand citizens are not required to be vaccinated to enter New Zealand due to Bill of Rights Act (1990) considerations, but other groups such as permanent residents and those holding visitor visas are. This creates a discrepancy with the approach taken with the maritime border where no travellers to New Zealand are required to be vaccinated.

6. The benefits from a public health perspective of requiring non-New Zealand citizens arriving by air to be vaccinated in order to prevent transmission of COVID-19 within New Zealand are no longer considered to outweigh the impacts. However, I consider that the requirement remains justified as a means of reducing pressures on the health system from people suffering from severe illness that are not eligible for publicly funded health care in New Zealand.

7. As New Zealand Residence Class Visa holders are eligible for publicly funded health care, I recommend that the vaccination requirement is removed for this class of traveller. Further

work is needed to consider whether it's operationally feasible to remove the requirement for other classes of traveller that are eligible for publicly funded healthcare.

8. The public health benefits of requiring people transiting New Zealand to be vaccinated are also no longer considered to outweigh the impacts this has on travellers and the air sector. I have proposed that this requirement be removed. If you agree to this advice, you may also choose to remove the requirement for transit passengers to hold a traveller pass issued by the New Zealand Traveller Declaration System as without the vaccination requirement, there is no practical use for this pass.

9. You are invited to discuss the options presented in this briefing further with Officials. Once your preferred options are known, the Ministry will work with the Parliamentary Counsel Office and other agencies on the approach needed to successfully operationalise the required changes to COVID-19 Orders, border settings and the New Zealand Traveller Declaration as soon as possible in May 2022.

Recommendations

I recommend you:

S9(2)(f)(iv)

[redacted]

Vaccination requirements

g)	**Note** that COVID-19 vaccination requirements were introduced in the context of the Delta variant and our Elimination Strategy before the introduction of Omicron and our domestic outbreak	**Noted**
h)	**Note** that the legal validity of the vaccination requirement under the Air Border Order rests on whether the requirement is an appropriate, justifiable and proportionate measure to prevent the risk of the outbreak or spread of COVID-19	**Noted**
i)	**Note** that from a public health perspective there is now a limited rationale for vaccination requirements as a condition of entry to New Zealand at the air and maritime border as a means of reducing the transmission of COVID-19	**Noted**
j)	**Note** that there remains a justification for requiring vaccination to prevent people who are not eligible for access to publicly funded healthcare entering New Zealand and suffering from illness that may require hospital level care	**Noted**
k)	**Agree** to remove the vaccination requirement for New Zealand Resident Class Visa Holders under the COVID-19 Public Health Response (Air Border) Order 2021	**Yes** / **No**
l)	**Note** that there are other classes of traveller to New Zealand who are eligible for publicly funded healthcare, but that further work is needed to ascertain if it's operationally feasible to disapply the vaccination requirement for each of these groups	**Noted**
m)	**Note** that I do not consider the benefits of the vaccination requirement for transit only passengers continue to outweigh the impact for travellers and the air sector	**Noted**
n)	**Note** that if the vaccination requirement is removed for transit passengers, there is no longer a clear purpose for requiring them to obtain a traveller pass under the New Zealand Traveller Declaration System	**Noted**
o)	**Agree** to remove the requirement for transit passengers to be vaccinated under the COVID-19 Public Health Response (Air Border) Order 2021	**Yes** / **No**
p)	**Agree** to remove the requirement in the COVID-19 Public Health Response (Air Border) Order 2021for transit passengers to have a traveller pass issued by the New Zealand Traveller Declaration System	**Yes** / **No**
q)	**Note** that following your indication of preferred options, Officials will work with the Parliamentary Counsel Office and operational agencies on the approach needed to successfully operationalise the proposed changes to COVID-19 Orders, border settings and the New Zealand Traveller Declaration	**Noted**

r)	**Note** that I intend to exempt Residence Class Visa holders from the vaccination requirement in the COVID-19 Public Health Response (Air Border) Order 2021 as soon as operational agencies are able to process this change	**Noted**

Dr Ashley Bloomfield
Te Tumu Whakarae mō te Hauora
Director-General of Health
Date: 28 April 2022

Hon Chris Hipkins
Minister for COVID-19 Response
Date: 29/4/2022

Review of pre-departure testing and vaccination requirements for arrivals to New Zealand

Context

10. New Zealand's Elimination Strategy, and now our minimisation and protection approach, has been successful in preventing the worst impacts of COVID-19. We have achieved this by keeping our public health measures constantly under review to ensure they are proportionate and supported by the latest evidence.

11. As a result, our COVID-19 border settings are gradually becoming less restrictive and are no longer required as a tool to reduce the flow of COVID-19 cases to New Zealand. In accordance with Cabinet's agreement to settings for the Reconnecting New Zealanders with the World programme an increasing number of groups can now enter New Zealand without any form of isolation or quarantine requirements. This reflects the changing risk profile at the border, our domestic situation and the Omicron variant being less virulent.

12. The associated public health requirements that exist to reduce the risk of transmission of COVID-19 through the air border have also been incrementally reduced as their justification has been reviewed. In addition to the removal of managed isolation and self-isolation requirements earlier this year, you have also recently agreed to remove the requirement that passengers must not display symptoms of COVID-19 on arrival to New Zealand and to reduce physical distancing requirements while in transit (HR 20220090 refers). The remaining public health measures[1] that apply to travellers to New Zealand are the requirements to:

    a. meet vaccination requirements (only those who are not New Zealand Citizens)
    b. have a pre-departure test or be excused by a medical certificate
    c. not exhibit symptoms of COVID-19 when boarding a direct flight to New Zealand
    d. not be subject to a public health direction in another country
    e. not have prematurely ended a period of isolation or quarantine
    f. wear a face covering in certain places and circumstances
    g. maintain 1-metre physical distancing while in transit, to the greatest extent reasonably practicable
    h. undertake a Rapid Antigen Test (RAT) on days 0/1 and 5/6 after arriving in New Zealand[2].

13. Many countries are also moving to reduce the restrictions they place on incoming travellers. The Ministry of Foreign Affairs and Trade has provided the updated International

[1] A range of administrative measures also apply including the need for travellers to make a travel declaration and hold a traveller pass, to answer to authorised officers, to produce evidence of compliance with COVID-19 provisions and to not provide false or misleading information or evidence

[2] As Minister Verrall is expected to present a paper to Cabinet on post arrival testing on 20 May 2022, this is not within the scope of this briefing

Comparison Table at Appendix One which outlines vaccination, testing and self-isolation requirements for a number of countries we compare ourselves to.

14. The volume of arrivals to New Zealand is expected to increase when Step 4 of Reconnecting New Zealanders commences at 11:59pm on Sunday 1 May 2022 which will allow entry of visa waiver travellers and existing holders of valid visitor visas (both onshore and offshore). From July, those holding Work Visas and Accredited Employer Work Visas will also be able to enter New Zealand.

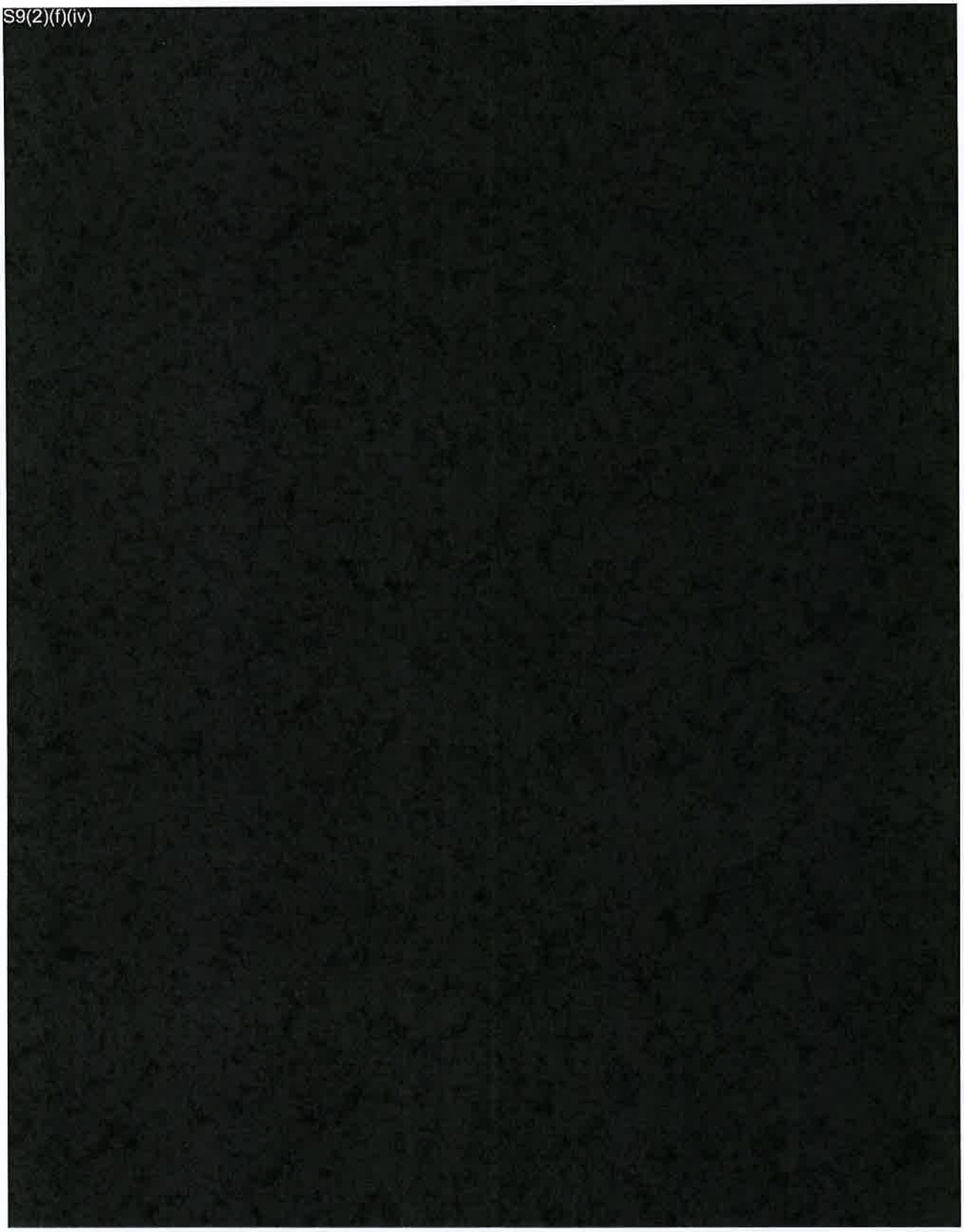
15. Having regard to this together with the prevalence of COVID-19 in the community and the obligations the Minister for COVID-19 Response and the Director General of Health have to keep COVID-19 Orders under review[3], it is timely to consider the pre-departure public health requirements that apply to travellers to New Zealand to ensure they remain fit for purpose. I have prioritised consideration of pre-departure testing and vaccination requirements in this context as I consider that these are the measures that impose the greatest impacts on travellers.

Pre-departure testing requirements

S9(2)(f)(iv)

[redacted]

[3] Section 14(5) of the COVID-19 Public Health Response Act (2020)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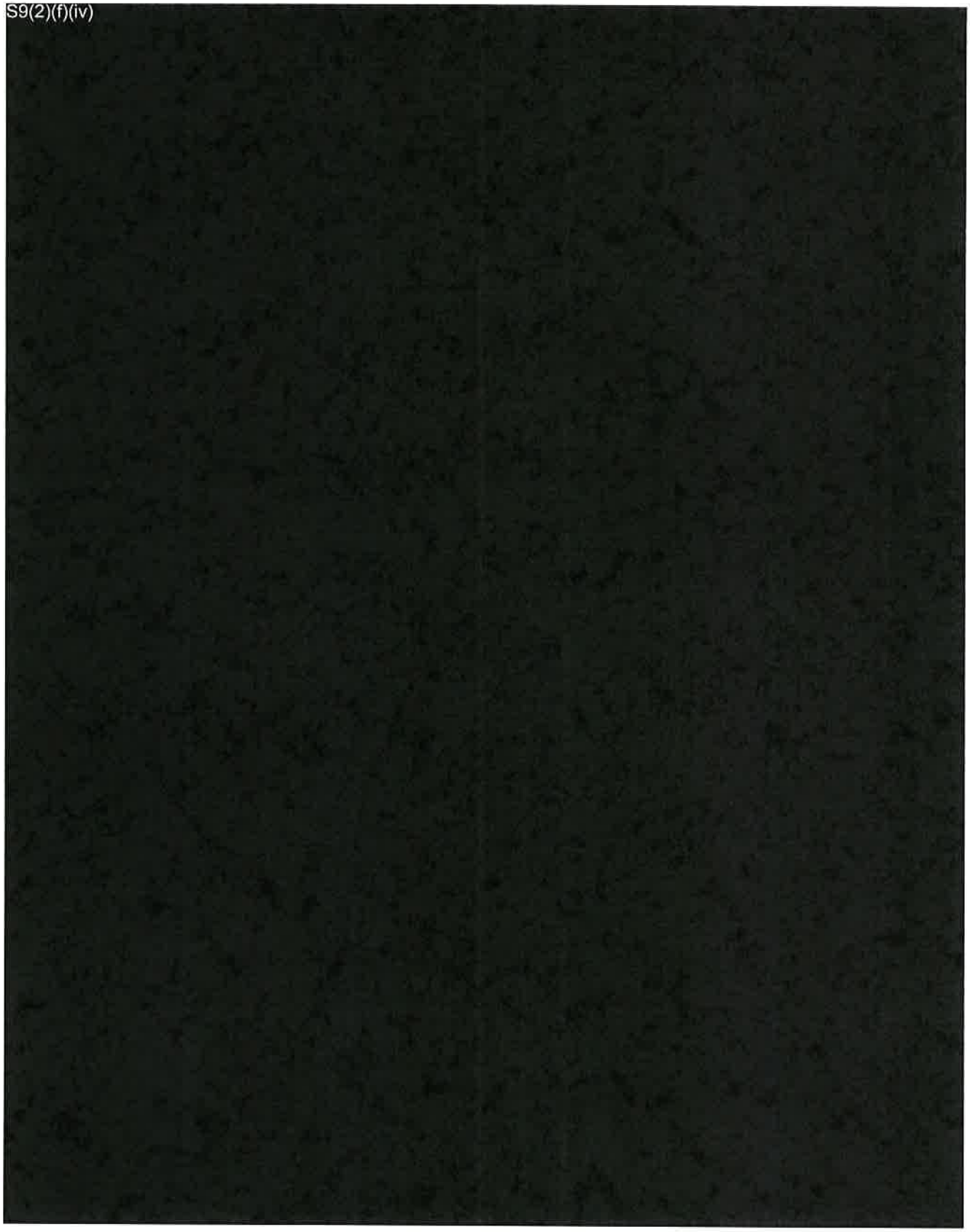

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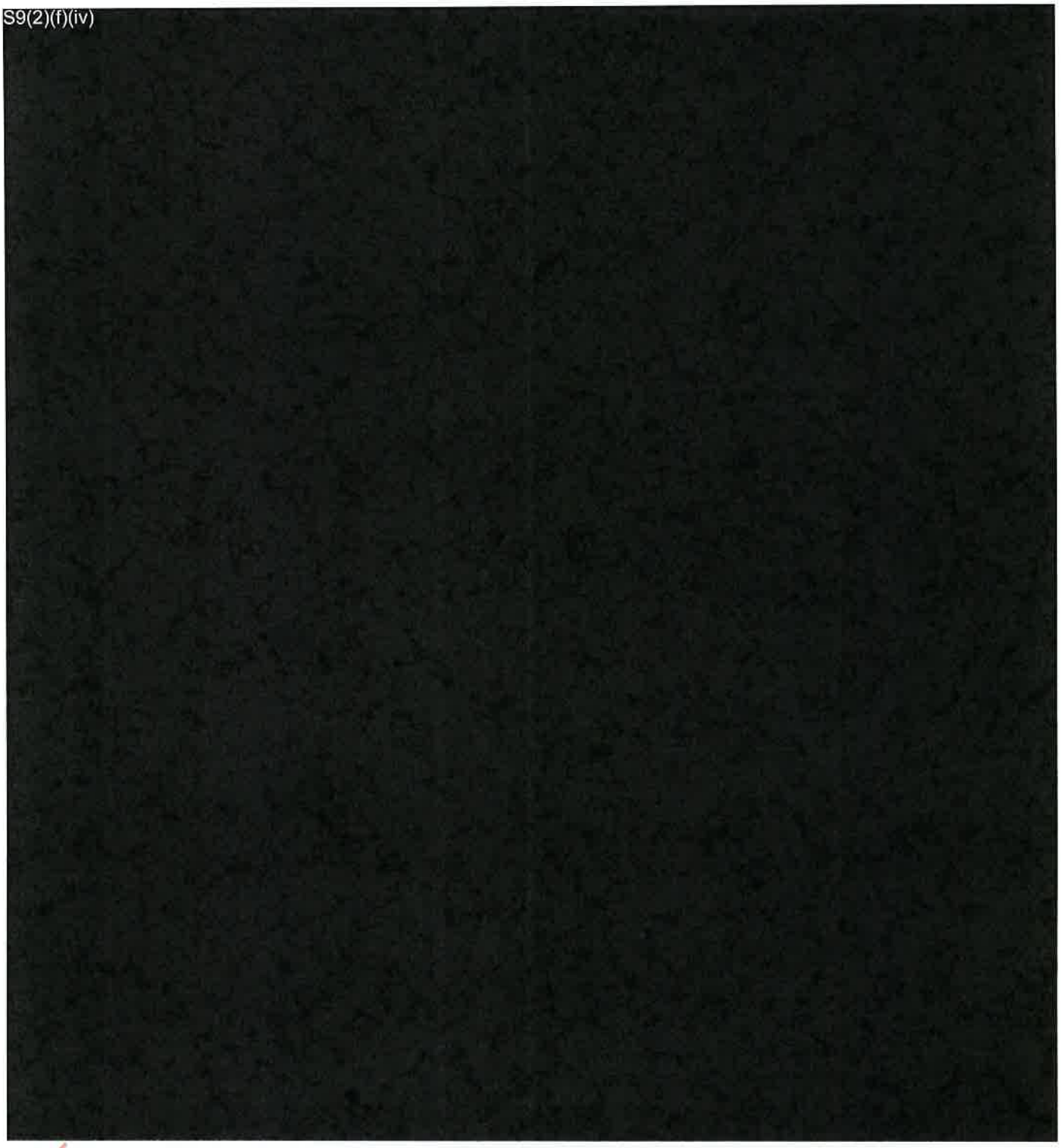

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Vaccination requirements

Original purpose of COVID-19 vaccination requirements

42. COVID-19 vaccination requirements for non-New Zealand citizens who arrive by air were first introduced as a further measure to reduce the risk of a COVID-19 outbreak on 1 November 2021. On 4 October 2021, Cabinet noted that this would not mitigate all residual risk but would:

    a. provide another tool to manage and reduce the risk from COVID-19 transmission

    b. encourage greater uptake of vaccination by non-citizens who wish to travel to New Zealand [CAB-21-MIN-0403 refers].

43. At the time, New Zealand's tight border settings provided a strong defence against the virus and placed a considerable limitation on border arrival volumes. Delta was the dominant variant circulating globally and New Zealand was responding to an outbreak that was likely to have originated from an incursion at the border.

44. Since introduction, the vaccination requirement has remained relatively unchanged, with some minor adjustments. For example:

    a. on 13 March 2022, the minimum 14-day period between final dose and departure for New Zealand was removed by Director-General notice

    b. on 14 March 2022 Cabinet agreed that unvaccinated arrivals should no longer be required to enter MIQF [CAB-22-MIN-0072 refers], and

    c. the list of accepted vaccines has been kept under review and new approved vaccines have been added as required.

45. Unlike at the air border, there are currently no vaccination requirements for people arriving in New Zealand by ship. This is because few people were arriving in New Zealand by ship, those who were (for example, crew of cargo ships) were subject to alternative controls that adequately mitigated the public health risk and imposing mandatory vaccination requirements for these arrivals would have had a significant impact on international shipping to and from New Zealand.

Shifting purpose of COVID-19 vaccination requirements

46. As noted above, New Zealand has now entered a new chapter in the COVID-19 response and the threat posed by the pandemic has shifted. The Omicron variant is many times more transmissible than the Delta variant and it is no longer possible to use the border as a key defence to keep the virus out.

47. From a public health perspective, and in the context of the current outbreak and high domestic vaccination rates, there is little difference in risk posed to the New Zealand community by arrivals who are either unvaccinated or who only meet the minimum vaccination requirements. The greater risk posed by these arrivals relates more to their individual risk of severe illness and the impacts this has on the capacity of the health system, rather than the risk of onwards transmission to others.

Bill of Rights Act Implications of COVID-19 vaccination requirements

49. Because vaccination requirements may limit the above rights, you must be satisfied that the limitation are demonstrably justified. You must therefore be satisfied that they remain necessary and proportionate in the interests of public health.

Review of COVID-19 vaccination requirements

50. The COVID-19 vaccination requirements for international arrivals have been in place for just over five months. As with all our measures, it is important that they are continually reviewed to ensure they remain effective and proportionate to the risk.

51. No expiry date was put in place when the requirement to be vaccinated was first introduced. However, Cabinet recognised the potential for the virus to adapt over time and the need to stay responsive to the risk. As such, Cabinet directed officials to undertake a review of the policy in the first quarter of 2022 and to advise on any modification that may be required. Cabinet noted that a review recognises that this policy has been developed as a short-term measure while longer term options were worked through [CAB-21-MIN-0403 refers].

52. The future role of vaccination requirements as a condition of entry to New Zealand was a topic for discussion at a recent meeting of the Reconnecting New Zealanders Ministerial Group.

Public Health advice

53. With the removal of My Vaccine Pass from the COVID-19 Protection Framework, and the narrowing of employment settings where vaccinations are mandated, there is now a limited rationale for vaccination requirements as a mandatory condition of entry to New Zealand at either the air or maritime border.

54. The public health benefit of requiring vaccination as a tool to reduce transmission of COVID-19 by travellers entering New Zealand is no longer considered to outweigh the impacts of this restriction. However, I consider that the benefits of the requirement do outweigh the impacts from the perspective of reducing pressures on the health system, noting that the approaching winter period is expected to result in increased rates of COVID-19 along with other seasonal illness in New Zealand.

Recommended changes

55. Having regard to the revised public health view on the benefits of vaccination, I consider that there are grounds to retain the vaccination requirement for travellers who are not

eligible for publicly funded healthcare in New Zealand under the Health and Disability Services Eligibility Direction 2011.[6]

56. I consider it important to require those that are not eligible for publicly funded healthcare to continue to be vaccinated. This is to prevent such travellers contracting severe illness from COVID-19 that requires hospital level care and displacing an eligible person's access to healthcare.

57. As New Zealand Residence Class Visa holders are eligible for publicly funded healthcare, I consider that the requirement to be vaccinated should no longer apply to this class of traveller.

58. Under the Health and Disability Services Eligibility Direction 2011 there are other classes of traveller that are eligible for publicly funded healthcare. This includes Australian Citizens that intend to live here for two years or more, Interim Visa holders and students studying in New Zealand on certain scholarships. Based on the public health rationale provided, there would also be merit in excusing these groups from the requirement to be vaccinated.

59. However, there are considerable operational challenges in identifying who is and is not eligible for publicly funded healthcare and assigning the associated requirements to each of these classes of travellers. More time is required for agencies to consider if it's feasible to differentiate between travellers in this way.

60. Despite the proposal to remove the vaccination requirement for Resident Class Visa holders, public health messaging will continue to strongly encourage all travellers to be vigilant about staying up to date with their COVID-19 vaccinations. If eligible, due and available to them, travellers would also be encouraged to be boosted before departing for New Zealand.

61. I also note that there are market driven incentives for travellers to keep up to date with COVID-19 vaccination. For example, many airlines still require this, and anecdotal evidence suggests that insurance companies are either refusing coverage to unvaccinated travellers or requiring them to pay a higher premium than vaccinated travellers.

The vaccination requirement for transit passengers

62. Currently, passengers transiting New Zealand are required to be vaccinated against COVID-19. As these passengers do not enter New Zealand, the rationale outlined above to preventing severe illness from COVID-19 that could impact on the capacity of the health system does not apply. The rationale for requiring vaccination for transit passengers is therefore limited to reducing the transmission of COVID-19 to other passengers, some of whom may be entering New Zealand. I no longer consider the benefits of this requirement outweigh its impacts.

63. I recommend that the requirement for passengers transiting New Zealand to be vaccinated is removed. You may also wish to consider removing the requirement for transit only passengers to complete a travel declaration and have a traveller pass is removed. This is because without the vaccination requirement there are no remaining restrictions or obligations for these passengers for the New Zealand Traveller Declaration System to

[6] https://www.health.govt.nz/system/files/documents/pages/eligibility-direction-2011.pdf

manage. This would relieve airlines of the operational challenges they face with this group of passengers.

Crown Law advice

S9(2)(h)

Equity

66. As articulated by the Courts and the Waitangi Tribunal, equity is a principle of Te Tiriti, and one of the principles recommended by the 2019 Hauora report for the Health system. Within this principle, it has been critical to ensure that any border settings changes implemented consider equitable outcomes.

67. The main equity consideration arising from the options in this paper is the recommendation to continue to require visitors to New Zealand who are not eligible for publicly funded healthcare in New Zealand to be vaccinated. The recommendation has been made in line with the fact that vaccine coverage continues to be an important protective measure and with the intention of ensuring that those ineligible for publicly funded healthcare do not displace those that are eligible.

Next steps

68. Officials would like to meet with you at your convenience to provide further information on each of the options presented in this briefing.

69. Following your indication of preferred options, Officials will work with the Parliamentary Counsel Office on the timing of any resulting amendment to the COVID-19 Public Health Response (Air Border) Order 2021.

70. As the New Zealand Traveller Declaration (NZTD) is a live system, any changes to it need to be carefully managed and there will need to be sufficient lead in time to provide for this.

71. However, Resident Class Visa Holders outside of New Zealand who do not intend to be vaccinated are currently unable to return to New Zealand. Having regard to the revised public health view on vaccination I do not consider it tenable to require this class of traveller to wait until an amendment to the Air Border Order and associated system

changes are able to be given effect. I propose to sign a Director-General class exemption from the vaccination requirement under the Air Border Order for Resident Class Visa holders which will allow them to return to New Zealand as soon as agencies are able to process this change.

ENDS.

Appendix One: COVID-19 Border Settings International Comparisons Table as of 21 April 2022

NEW ZEALAND FOREIGN AFFAIRS & TRADE

UNCLASSIFIED

International Comparison Table - Border Settings

This report is produced by the MFAT COVID Policy and Coordination Division. We intend for the main use of this data to be comparing across multiple jurisdictions, and advise verification before relying on any individual data point. Changes since 18 March (previous report) shown in red.

21.04.2022

Jurisdiction	Vaccine status differentiation	Travel history differentiation	General border settings	Definition of Fully Vaccinated for the purposes of border settings	Testing requirements *(pre-departure, post-arrival)*	MIQ or self-isolation *(Type of isolation required, number of days required)*
Australia	Yes - non-citizens must be vaccinated to enter (some exceptions)	No	Open to vaccinated non-citizen travellers (subject to usual immigration processes). From 21 February 2022, all visa holders who are fully vaccinated for international travel purposes can travel to Australia without a travel exemption. Unvaccinated visa holders will still need to be in an exempt category or hold an individual travel exemption to enter Australia.	Completed a primary course of a vaccine approved or recognised by the Therapeutic Goods Administration (TGA), at least 7 days before arrival. Incl mixed doses (if both on approved list). Two doses at least 14 days apart of: AstraZeneca Vaxzevria AstraZeneca Covishield Pfizer Moderna Sinovac Coronavac Bharat Biotech Covaxin Sinopharm BBIBP-CorV (for people under 60 years of age on arrival in Australia) Sputnik V Novavax Or one dose of: Johnson & Johnson *(differs for indirect international arrivals to Western Australia, three doses required)*	Pre-departure: Not required Post-arrival: Varies by state. *Vaccinated arrivals:* RAT or PCR test generally required within first 24 hours of arrival (within 12 hours in Western Australia). *Non-vaccinated arrivals:* RAT or PCR test generally required within first 24 hours of arrival. Testing on subsequent days may also be required (for example, South Australia required on days 6 and 13).	Type of Isolation Required: Varies by state. *Vaccinated arrivals:* Self-isolation until return of negative day 0/1 test *Non-vaccinated arrivals:* MIQ or self-isolation: 7 - 14 days
Canada	Yes - non-citizens must be vaccinated to enter (some exceptions)	No	Open to vaccinated non-citizen travellers. Fully vaccinated foreign nationals may be allowed to enter Canada for discretionary travel. Foreign nationals who don't qualify as fully vaccinated will only be allowed to enter in specific circumstances. Unvaccinated Canadian citizens (including dual citizens), people registered under the Indian Act, permanent residents of Canada, or protected persons (refugee status) are allowed to enter Canada.	Completed a primary course of a vaccine approved by the Government of Canada, at least 14 days before arrival. Incl mixed doses (if both on approved list). Accepted vaccines: AstraZeneca/COVISHIELD Bharat Biotech Covaxin Johnson & Johnson Medicago Covifenz Moderna Novavax Pfizer(including for children aged 5 to 11 years) Sinopharm BIBP Sinovac CoronaVac	Pre-departure: *Vaccinated arrivals:* Not required *Unvaccinated arrivals:* Molecular test (incl CRISPR, Ct, E gene, N gene, Orf1a/b, RdRp gene, S gene, ddPCR, LamPORE, NAAT, NAT, NGS, PCR, qPCR, RNA, RT-LAMP, RT-PCR, WGS test (72 hours) or RAT (1 day) - must be professionally administered or observed. (Applies to travellers over age 5, some exceptions). Post-arrival: *Vaccinated arrivals*: Mandatory randomized arrival testing (not required to quarantine while awaiting test result, but must isolate 10 days if test positive). *Non-vaccinated arrivals:* On arrival, Day 8	Type of Isolation Required: *Vaccinated arrivals:* Not required *Non-vaccinated arrivals:* Self-isolation, 14 days

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Jurisdiction	Vaccine status differentiation	Travel history differentiation	General border settings	Definition of Fully Vaccinated for the purposes of border settings	Testing requirements *(pre-departure, post-arrival)*	MIQ or self-isolation *(Type of isolation required, number of days required)*
China	No - non-citizens must declare vaccination status, but entry is not differentiated on this basis	No - some minor differences in entry requirements based on jurisdictions arriving from	**Closed to most.** Those allowed to enter include citizens, residents with valid visas, diplomats, C visa holders (air & sea crews) and those able to enter under an exemption process (e.g. for 'necessary trade' or humanitarian reasons).	Not applicable	**Pre-departure:** Nucleic Acid or IgM antibody tests (timeframe varies depending on departure point) **Post-arrival:** Nucleic acid tests on day of arrival then on the 7th, 14th, 21st and 28th day.	**Type of Isolation Required:** Managed isolation, 14-21 days depending on port of entry (for example, Shanghai is 14, Beijing 21) On 12 April, Chinese media reported that a pilot program had launched in eight cities to reduce the total quarantine time for international arrivals from 14 to 10 days. However, articles sharing this news have since been removed. **Isolation period remains a minimum of 14 days.**
Denmark	No - unless travelling to Greenland	No	Open	Not applicable (unless travelling to Greenland until 2 June)	**Pre-departure:** None **Post-arrival:** None	**Type of Isolation Required:** None
France	**Yes** - some differences in testing requirements based on vaccination status. Unvaccinated travellers from orange list country must provide compelling reason to travel.	No - green/ orange/ red country categories, with entry limited for travellers from red list countries **but no countries currently red.**	**Open.** In the event of an emergency (for example emergence of variant likely to present a risk of increased transmissibility or immune escape) a country may be placed on the "red list" requiring travellers to demonstrate compelling reason to travel and to prove vaccination status, undergo testing and isolation. There are currently no countries on the red list.	**Persons aged 18 and over must have received an approved primary course AND a booster dose of messenger RNA vaccine no later than 270 days after receiving the last mandatory dose.** A primary course is considered complete after vaccination with vaccine approved by the European Medicines Agency (EMA) *28 days after receiving one dose of:* Johnson & Johnson *Seven days after second dose of:* Pfizer Moderna AstraZeneca/Vaxzevria/Covishield OR/ all required doses of a WHO-licensed vaccine not approved by the EMA AND seven days after receiving an additional dose of a duly approved mRNA vaccine.	**Pre-departure:** *Vaccinated arrivals*: None *Non-vaccinated (or recovered) arrivals:* PCR (72 hours) or RAT (48 hours) **Post-arrival:** *From green country:* None *Unvaccinated arrivals from orange country:* Randomized testing	**Type of Isolation Required:** *From green country:* None *From orange country:* None *From red country:* Self-isolation, 7 days
Germany	Yes - some differences in testing requirements	No - some differences in entry requirements - there are two categories of "risk-areas": high-risk areas and areas of variants of concern. No areas currently considered risk areas.	**Open.** Travellers from "risk-free" areas can enter Germany regardless of the purpose of their travel. However, travellers arriving from a "high risk area" (none at present) or an "area of variants of concern" (none at present) must be fully vaccinated and are subject to other requirements. Proof of vaccination or recovery is deemed equivalent to a negative test result within the context of the obligation to furnish proof.	**Completed a primary course of a vaccine approved by the Robert Koch Institute, at least 14 days before arrival, and at most 270 days since last dose. Specified combinations accepted.** **Two doses of the following:** Pfizer Moderna AstraZeneca Johnson & Johnson Novavax	**Pre-departure:** *Vaccinated or recovered arrival:* Not Required *Travel from an area of variants of concern (currently none):* Required *Unvaccinated or recovered arrival from non-area of variants of concern:* Required If required, RAT (48 hours before arrival) or LAMP, NAATm PCR, RT-LAMP, RT-LAMP or TMA (48 hours before departure) **Post-arrival:** *From green country:* None *Unvaccinated arrivals from orange country:* May be required	**Type of Isolation Required:** *Travel from an high risk area or area of variants of concern (applies to both vaccinated or unvaccinated):* Self-isolation *Travel from elsewhere:* None **Number of Days of Isolation Required:** *From high risk area:* 10 (can be ended early by submitting proof of vaccination or recovery or a negative test result) *From area of variants of concern:* 14

Jurisdiction	Vaccine status differentiation	Travel history differentiation	General border settings	Definition of Fully Vaccinated for the purposes of border settings	Testing requirements *(pre-departure, post-arrival)*	MIQ or self-isolation *(type of isolation required, number of days required)*
Ireland	No	No	Open.	Not applicable	None	None
Japan	Yes - some differences in quarantine & testing requirements	Yes - some differences in quarantine requirements for arrivals from a designated "high risk Omicron location".	Restricted. The government has begun processing applications from business people and students wanting to enter Japan. From 14 March, the government increased the daily cap of arrivals at Japan's border from 5,000 people to 7,000 people. The government has undertaken to further increase the daily cap in a staged manner.	Completed a primary course of an approved vaccine (combinations accepted) and a third/booster dose of an mRNA vaccine (Pfizer or Moderna only). Accepted vaccines: Pfizer Moderna AstraZeneca Bharat Biotech Covaxin Janssen (one dose considered complete primary course)	Pre-departure: *All:* LAMP, NEAR, Next Generation Sequence, quantitative antigen (CLEIA/ECLEIA), OCR, RT-PCR, Smart Amp, TMA or TRC (72 hours). Post-arrival: *All:* PCR test, on arrival at airport. *Fully vaccinated arrival from designated area*: Day 3 *Unvaccinated travelling from designated area:* Day 3 *Fully vaccinated arrival from non-designated area:* None *Unvaccinated travelling from non-designated area:* Day 3	Type of Isolation Required: *Fully vaccinated (boosted) travelling from designated area*: Self-isolate, 3 days subject to negative test, otherwise 7 *Unvaccinated travelling from designated area:* MIQ, 3 days *Fully vaccinated (boosted) travelling from non-designated area:* None *Unvaccinated travelling from non-designated area:* Self-isolate, 3 days subject to negative test, otherwise 7
Singapore	Yes	Yes - some differences in requirements for arrivals from restricted areas. No areas currently restricted.	Open for vaccinated travellers (subject to travel history requirements - that is, not having travelled in a restricted area - of which there are currently none - in the past 7 days).	Travellers are considered fully vaccinated if they received a full course of WHO EUL Vaccines from a specific manufacturer, at least 2 weeks before arrival and meet the minimum dose interval period (below). Accepted vaccines: Pfizer, dose interval 17 days Moderna, dose interval 24 days AstraZeneca/Covishield, dose interval 24 days Janssen, dose interval N/A Sinopharm, dose interval 17 days (must have a third dose for domestic movement purposes) Sinovac, dose interval 13 days (must have a third dose for domestic movement purposes) Covaxin, dose interval 24 days Novavax, dose interval 17 days Combination doses, dose interval 17 days	Pre-departure: *All:* PCR or RAT (2 days) Post-arrival: *Fully vaccinated arrival*: Not required. *Unvacinated arrival:* PCR day 7 (test on arrival may be required if symptomatic) *Travel from restricted area:* On arrival PCR test & day 7	Type of Isolation Required: *Fully vaccinated arrival:* None *Unvacinated arrival:* Self-isolation, 7 days *Travel from restricted area:* Self-isolation, 7 days
South Korea	Yes - some differences in quarantine requirements	No	Open for certain visa categories (visa-waiver travel suspended).	Travellers are considered fully vaccinated 14 days after full primary course (valid up to 180 days) or with booster shots.Accepted vaccines: AstraZeneca/COVISHIELD Bharat Biotech Covaxin Johnson & Johnson Moderna Novavax/COVOVAX Pfizer Sinopharm BIBP Sinovac CoronaVac	Pre-departure: *All:* LAMP, NAAT, NEAR, PCR, RT-PCR, SDA or TMA (2 days) Post-arrival: On arrival, day 6/7. If short-term visa or visitor is required to stay at government managed quarantine facilities, they would have to have 3 PCR tests rather than 2 PCR test.	Type of Isolation Required: *Fully vaccinated:* None *Unvaccinated, long term entrant or resident:* Self-isolation, 7 days *Unvaccinated, short term entrant:* MIQ, 7 days

Jurisdiction	Vaccine status differentiation	Travel history differentiation	General border settings	Definition of Fully Vaccinated for the purposes of border settings	Testing requirements *(pre-departure, post-arrival)*	MIQ or self-isolation *(Type of isolation required, number of days required)*
United Arab Emirates	Yes - some differences in testing requirements	No	Open. Settings vary by arrival city.	**Vaccines accepted are WHO-EUL vaccines and/or approved by the United Arab Emirates.** **Accepted vaccines:** AstraZeneca/COVISHIELD Bharat Biotech Covaxin Johnson & Johnson Moderna Novavax/COVOVAX Pfizer Sinopharm BIBP Sinovac CoronaVac Sputnik	**Pre-departure:** *Vaccinated travellers*: None *Unvaccinated travellers*: PCR (48 hours) **Post-arrival:** May be requested by authorities. UAE-citizens arriving in Dubai are exempt from pre-departure test requirements but require test on arrival	**Type of Isolation Required:** Arrive in Dubai: None Arrive in Abu Dhabi: None
United Kingdom	No	No	Open.	Not applicable	None	None
United States	Yes - non-citizens must be vaccinated to enter (some exceptions)	No	Open to vaccinated non-citizen travellers.	**Completed a primary course of a vaccine approved by the US FDA or WHO-EUL or approved clinical trials, at least 14 days before arrival. Incl mixed doses (if dose interval at least 17 days).** Accepted vaccines: *Single dose:* Janssen/J&J *2-dose series:* Pfizer-BioNTech Moderna AstraZeneca Covaxin Covishield BIBP/Sinopharm Sinovac Novavax/Covovax Medicago	**Pre-departure:** Antigen, NAAT, RT-LAMP, RT-PCR or TMA (One day) (exemption for US citizens arriving from Belarus, Russia and Ukraine) **Post-arrival:** None (but test 3-5 days after arrival recommended)	**Type of Isolation Required:** None (but self-isolation 5 days recommended if unvaccinated)

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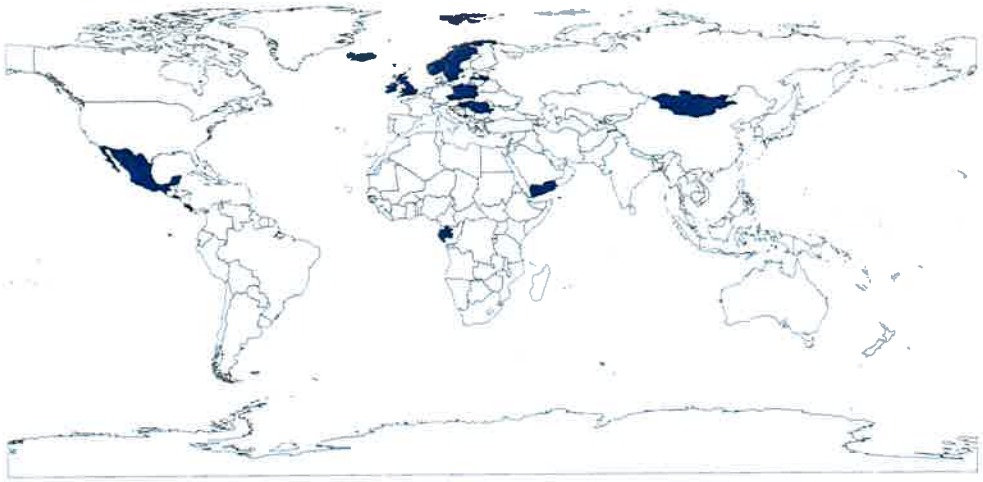
Jurisdiction	Vaccine status differentiation	Travel history differentiation	General border settings	Definition of Fully Vaccinated for the purposes of border settings	Testing requirements *(pre-departure, post-arrival)*	MIQ or self-isolation *(Type of isolation required, number of days required)*

COVID-19 Restriction-free countries, from UNWTO/IATA Destination Tracker, accessed 21 April 2022



According to analysis by the United Nations World Tourism Organisation, 20 jurisdictions had removed all COVID-19 related travel restrictions, as of 14 April 2022.