Te Whatu Ora
Health New Zealand

Briefing

Health System Readiness and Response to Variants of Concern

Date:	22 September 2022	**Priority:**	High
Security classification:	In Confidence	**Tracking number:**	HNZ00003850

Action sought		
	Action sought	**Requested by**
Hon Dr Ayesha Verrall **Minister for COVID-19 Response**	Noting paper on health system operational readiness to respond to a Variant of Concern and decision on future of the NZ COVID Tracer App.	Click here to enter a date.
Hon Andrew Little **Minister of Health**	Copied to.	

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Matt Hannant	Director, Outbreak Response	S9(2)(a)	✓
Dani Coplon	Critical Projects Lead, Outbreak Response	S9(2)(a)	

Minister's office to complete:

- ☐ Approved
- ☐ Noted
- ☐ Seen
- ☐ See Minister's Notes
- ☐ Declined
- ☐ Needs change
- ☐ Overtaken by Events
- ☐ Withdrawn

Comments

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Purpose

1. This briefing provides you with a detailed report back on health system preparedness and readiness to respond to future COVID-19 Variants of Concern (VoC) [CAB -22-MIN – 0223], and also seeks your decision on the future of the NZ COVID Tracer App.

Summary

2. New Zealand's response to COVID-19 has been world leading and has kept many people safe from the worst effects of the pandemic.

3. Throughout the COVID-19 pandemic, we have developed and maintained a robust set of public health measures to respond to any VoC if required. There have been many lessons learned and a wealth of knowledge has been gained.

4. We now have the required baseline and reserve measures in place that will best get us through the next phase of the COVID-19 pandemic, emerging VoC, and further global pandemics.

5. We know how to better target resources to achieve more equitable outcomes for our priority populations. A renewed focus in the event of a new variant, would hasten the deployment of tailored services and information to support Māori, Pacific, disabled people and ethnic communities.

6. To inform preparedness across government, Manatū Hauora alongside Outbreak Response, within the National Public Health Service (NPHS) in Te Whatu Ora have developed five variant scenarios. Each scenario reflects a VoC with differing severity and degree of transmissibility. The five scenarios are outlined in the Variants of Concern Strategic Framework (the Framework).

7. The Framework is built on scientific research, global responses to date, and operational considerations. It outlines the different public health measures and how they would differ based on each of the variant scenarios, for example, what would happen regarding testing, contact tracing, isolation, and testing.

8. Under this framework, we will continue to rely on a multi-layered system of defence to ensure our systems, service providers and communities are resilient, our most vulnerable are protected, and that any disruptions to health, business, social and education outcomes are minimised.

9. Underpinning the response measures available to us are the foundations supporting these measures, what we call our 'core enablers' of preparedness, readiness and response. These enablers sit across the health system, are interdependent, and together make up essential components of an effective COVID-19 response.

10. Our enablers are based on the World Health Organisations (WHO) recent release of the 2022 COVID-19 Strategic Preparedness and Response Plan and include:

- surveillance, outbreak investigation
- laboratories and diagnostics
- infection prevention and control (IPC) and protection of the health and disability workforce
- case management, clinical operations and therapeutics
- strengthening essential health services and systems
- vaccination
- risk communication, community engagement and infodemic management.

11. Sustaining our core enablers make us less reliant on response measures and strengthens our resilience across the health system.

Recommended action

12. Te Whatu Ora recommends that you:

a) **Note** that investing in baseline measures will help to improve the capacity and capability of New Zealand to absorb COVID-19 related impacts, which in turn will help to reduce or delay the need to deploy more restrictive, reserve measures; Noted

b) **Note** that should a new VoC be identified, Manatū Hauora will assess its likely health impact in the New Zealand context and the Director-General of Health will alert COVID-19 Ministers if this assessment suggests severe adverse health outcomes are likely; Noted

c) **Note** that at the same time as b) is occurring, a lead agencies response process would be triggered to develop system advice on the sequencing, thresholds for introduction, and combination of response measures considered desirable to respond to the variant; Noted

d) **Note** that undertaking preparedness activities, guided by the five scenarios, enhances New Zealand's ability to effectively respond to new variants rather than represent commitments to particular courses of action; Noted

e) **Note** that the health and disability system preparedness for variants work is well advanced, and includes development of operational readiness plans for each of the five scenarios, and operational changes that can be scaled within baseline measures; Noted

f) **Note** The NZ COVID Tracer App cannot currently be utilised for other communicable diseases due to the Apple and Google Terms of Use. These global contracts, spanning across jurisdictions, restrict data use to COVID-19; Noted

g) **Agree** to maintain current functionality (in low maintenance mode) of NZ COVID Tracer until December 2022; and from December 2022 Yes / No

onwards, to reduce the scope to Bluetooth only, with a review of this in May 2023;

or

Yes/No

Agree for Te Whatu Ora Officials to provide further advice regarding the digital enablers to support contact tracing for VOCs and other communicable diseases;

h) **Note** that the ongoing health system response to Omicron has represented a cost beyond what we could have prepared for; Noted

i) **Note** that further advice will be provided to you regarding the financial position of the health system response to COVID-19, for your discussion with the Minister of Finance; Noted

j) **Note** that a report back will be provided to you on the transition of Care in the Community functions into business as usual operations in early October. Noted

Nick Chamberlain
National Director, National Public Health Service

22 / 09 / 22

Hon Dr Ayesha Verrall
Minister for COVID-19 Response

29 / 10 / 22

Background

13. On 13 June 2022, you presented a paper to Cabinet (the Cabinet paper) outlining New Zealand's approach to responding to COVID-19 VoC and provided an initial overview of preparedness across the health system and non-health COVID-19 response agencies [CAB-22-MIN-0223].

14. The Cabinet paper outlined that while the COVID-19 pandemic is now on a relatively known trajectory, its path is ultimately unpredictable. In order to ensure we are able to respond adequately to a VoC if required, we must undertake robust preparedness across government.

15. Cabinet directed Manatū Hauora with support from Te Whatu Ora and Te Aka Whai Ora to report back on health system preparedness, including but not limited to detail of anticipated testing modality and capacity requirements, contact tracing approach, and resource requirements across scenarios and outbreak stages. The operational responsibilities for the COVID-19 transitioned to Te Whatu Ora on 1 July 2022.

16. This briefing details the ongoing work to strengthen core components of preparedness across our health system and enable us to be well prepared for any VoC while supporting resilience across our health system.

Strategic approach to new variants of concern

Variants of Concern Strategic Framework

17. To assist preparedness and response planning for a VoC, Manatū Hauora developed the Variants of Concern Strategic Framework.

18. The Framework considers five different, plausible but hypothetical VoC scenarios, from worst to best case scenario. These scenarios are:

    - scenario 1: High clinical severity, high immune escape (worst case)
    - scenario 2: Low clinical severity, high immune escape
    - scenario 3: High clinical severity, low immune escape
    - scenario 4: Low clinical severity, low immune escape (best case)
    - scenario 5: Multiple co-circulating variants with different levels of severity and different levels of cross-protection.

19. It is important to note that the characteristics of any new VoC are ultimately unknown, including its transmissibility and clinical impacts. However, what is known is that any new VoC will likely be more infectious than previous variants to be able to gain a foothold.

20. At the overarching level, the objectives to any response remain the same: reduce and control the incidence of COVID-19 infections and prevent, diagnose and treat COVID-19 to reduce mortality, mobility and long-term clinical impacts.

21. To support these overarching objectives the Variants of Concern Strategic Framework sets out a response framework, which is applied across scenarios and made up of

specific objectives. This is dependent on the maturity of any VoC approaching the border or within the community.

22. These response objectives are:

    - **prepare:** system is alerted to a new VoC – system readies to pivot and if needed to move to contain
    - **contain**: first community case – system pivots to reduce transmission
    - **manage:** widespread community transmission – system pivots to preserving critical infrastructure and protecting communities at greater risk and priority populations.

Aligning the strategic direction with new approach to COVID-19

23. Since the development of the Variants of Concern Strategic Framework, New Zealand has shifted its approach in responding to COVID-19. On 12 September 2022, the Government announced the end of the COVID-19 Protection Framework.

24. The new, ongoing approach to COVID-19, builds on the Variants of Concern Strategic Framework [CAB-22-MIN-0223; CAB-22-MIN-0380 refers]. The goal of the Government's COVID-19 response is still protecting lives and livelihoods, reflected in four principles: prepared, protective and resilient, and stable.

25. This is an enduring approach that can flex with the context and challenges that COVID-19 will present. It means managing COVID-19 more like other infectious diseases, based on its impact on the health system and society. This approach relies on good voluntary compliance with core public health advice as foundation (baseline measures) and retains the ability to dial-up and layer on restrictions and requirements, if/when needed (reserve measures). The use of these measures and the overall approach for responding to VoC is outlined in the Variants of Concern Strategic Framework.

26. To maintain and enhance our preparedness for new VoC, a wide range of initiatives have been undertaken. These initiatives are intended to either bolster baseline measures to minimise the need for reserve measures to be used and to maintain stability or ensure that reserve measures can be re-instated quickly and effectively.

Health system preparedness

We have a robust set of public health response measures available to us

27. With over two years of a dedicated response to COVID-19, we have developed and maintained a robust set of public health measures to respond to any VoC if required.

28. What measures we implement in response to a VoC depend on a range of factors including the impact of the VoC on health outcomes, broader socio-economic impacts, as well as considerations on expected pressures on the health system.

29. While we have the tools available to us to respond to an emerging threat, many of these response measures are only required when the threat is great enough to warrant them. As the threat of Omicron decreases over time, we no longer require as many of these public health measures in place as part of our ongoing response.

30. As indicated in CAB-22-MIN-0223, many public health measures available to us exist within a set of 'reserve measures'- available to us to respond with only when it is proportionate to do so. As Omicron cases continue to track down, we are increasingly able to transition remaining public health measures into our set of reserves.

31. While we continue to transition our system and infrastructure to be more resilient to shocks through preparedness planning, we also need to consider how and when we would reactivate reserve measures or enhance baseline measures proportionate to health risk if they were required.

Role of Public Health Risk Assessments

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

33. The most recent PHRA, undertaken on 17 August 2022, noted that New Zealand's current COVID-19 outbreak is waning, with reducing case numbers, hospitalisations, and deaths. Modelling suggested that this trend should continue for some time. However, it is still unclear when the outbreak will plateau.

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

35. The next PHRA is planned for the week commencing 3 October 2022, which will provide the basis for further advice to Ministers in mid-October on whether public health measures relying on orders under the COVID-19 Public Health Response Act 2020 continue to be justified beyond this time.

36. The process by which we support the PHRA with operational considerations will be retained while the COVID-19 Public Health Response Act 2020 (the Act) is in place and until such time as adjustments can be made to other legal frameworks to manage communicable disease and pandemics more broadly are strengthened.

Legal framework

37. Work to consider the legal implications for future responses is being progressed by Manatū Hauora, in partnership with the Department of Prime Minister and Cabinet (DPMC).

38. To support the ongoing management of COVID-19 in the medium term, the Act will be extended beyond May 2023, when it is currently due to expire. Work on substantive legislative amendments for responding to future epidemics will take place over the next two or more years to enable recommendations from any formal inquiry into the COVID-19 response to be incorporated into the design of the future legislative work.

Readiness planning and assessments

39. Throughout July and August, Te Whatu Ora alongside Manatū Hauora, including the Public Health Agency (PHA), have undertaken readiness exercises.

40. Outbreak Response, NPHS have led a readiness assessment against all key metrics as agreed and confirmed with Ministers as part of ongoing work to provide assurances that all pillars across the COVID-19 Response are being addressed, to provide an assurance that preventative measures are in place to alleviate stress and burden on healthcare settings.

41. A VoC readiness assessment has been completed to provide an assurance that the system can respond if a VoC was to present via global surveillance or domestic surveillance.

42. The results suggest that there were some further operational refinements that could be made to better target the use of testing, surveillance and enabling operational mechanisms within Care in the Community.

43. These refinements have resulted in an update to testing guidance, further refinements and reviews of contact tracing and isolation requirements, streamlined clinical assessment criteria in Care in Community and reviewed infection, prevention and control advice.

44. Te Whatu Ora has also worked alongside agency partners across the All of Government response led by DPMC to support broad readiness planning for a Variant of Concern and sustained management of our current Omicron response.

45. It is recognised that in the worst-case scenario, quarantine or isolation facilities may be necessary to respond to a new variant. While our Managed Isolation and Quarantine (MIQ) network has been decommissioned, a readiness plan has been developed to support activation of quarantine and isolation capability if needed.

46. The Readiness Plan, when activated, will enable the Government to rapidly stand-up quarantine and isolation capability within 3-4 weeks[1] as part of border control measures in response to a significant public health threat. It is predicated on sufficient surge workforces being made available urgently by partner agencies (in particular health and defence force staff) and a full border closure being in place (or in the process of being implemented) when the Plan is activated, and that quarantine and isolation capability will be in support of border arrivals.

47. We have also actively repurposed some of our work with VoC, to put in place a strategic prepare and readiness framework for use across novel virus and other communicable disease. Our recent response to Monkeypox has shown how far we have come since 2020 in our ability to manage a local response that is regionally led and nationally enabled.

48. Given the work that has been undertaken, we believe that we remain prepared and ready for a VoC.

Core enablers of preparedness

49. Underpinning the response measures available to us are the foundations supporting these measures, what we call our 'core enablers' of preparedness, readiness and response. These enablers sit across the health system, are interdependent and together make up essential components of an effective COVID-19 response.

50. Our enablers are based on the WHO's recent release of the 2022 COVID-19 Strategic Preparedness and Response plan and include:

- surveillance, outbreak investigation
- laboratories and diagnostics
- IPC and protection of the health and disability workforce

[1] The plan assumes that self isolation will be the interim default position while quarantine and isolation capability is re-established and that other appropriate steps will be taken in parallel (for example pre departure tests) to ensure that risk is kept offshore as much as possible. If a border closure were implemented with no self isolation option in the interim period while MIQ was being re established, this would likely result in significant cases of distress among stranded offshore New Zealanders; this would be compounded by a likely immediate reduction of commercial inbound air route capacity. This issue would be of a type and scale that could not be managed or resolved via consular support from New Zealand officials offshore.

[redacted]

- case management, clinical operations and therapeutics
- strengthening essential health services and systems
- vaccination
- risk communication, community engagement and infodemic management.

51. We cannot operationalise any response measures without sustaining our core enablers.
52. We are continuing to transition our Omicron response away from requiring specific response measures, towards managing it within business-as usual activities. Sustaining baseline activities across core components of response ensure we maintain strong foundations across the health system and embed the lessons we have learnt as a result of COVID-19. This also allows us to surge and respond to any VoC if required while also improving resilience across the health system.
53. We continue to undertake significant operational work and refinement of our tools to maintain and improve preparedness and support resilience by continuing to strengthen activities across our core enablers. This work is outlined below.

Surveillance, outbreak investigation

54. Maintaining and strengthening surveillance globally remains vital to track the spread and evolution of COVID-19 and any other communicable or novel disease.
55. Outbreak investigation is core business for public health services across the country, and until the Omicron response, public health services were front and centre of the response. Regional and local public health services (formerly public health units) have been funded to maintain capability and capacity to respond to new VoC, should they be required. Depending on the VoC, public health services have the skills and capacity to undertake case investigation, contact tracing, and outbreak investigation, with a particular focus on high-risk settings and priority populations, including iwi, hapū, whānau and hapori Māori and Pacific peoples.

Ongoing surveillance activities

56. Surveillance retains a focus on monitoring COVID-19 nationwide as we shift to a post-peak 'baseline' rate of infections to ensure that we can quickly detect a new VoC. Our comprehensive approach to surveillance, including our priorities and key activities, has already been considered and endorsed by Cabinet [CAB-22-MIN-0161 refers].
57. The intelligence teams gather data both qualitative and quantitative from over 40 data sources globally and leverages data and intelligence at a local regional and national level.
58. International scanning is undertaken regularly by Intelligence, Surveillance and Knowledge (ISK) within the PHA, in the form of scanning global trends in cases, hospitalisations, deaths and VoC (through government sites/reports and articles). This is pulled into regular reports such as the weekly Trends and Insights report as well as other ad hoc reporting.
59. Manatū Hauora's Global Health team work closely with the Ministry of Foreign Affairs and Trade's (MFAT) Security and Organisational Resilience Division (SORD) and can facilitate the sourcing of reporting via MFAT's formal message system, from New Zealand's offshore Embassy/Post network. MFAT's reporting system has delivered helpful updates on the international state of play regarding variants of concern monitoring/surveillance across the following countries/jurisdictions.

[redacted]

We have adjusted settings to take a more strategic approach to COVID-19 surveillance

60. Up until recently surveillance has been focused on tracking data related to identified and confirmed cases, localities and transmission rates. This information helped us to understand the public health risk and appropriate response measures in the previous absence of vaccines and therapeutics. However, with much higher vaccination rates and increasing immunity among the population, we identified the need to reallocate resources to enable a more strategic and sustainable approach to COVID-19 surveillance. We have now adjusted systems to focus on tracking morbidity and impact by strengthening the surveillance of hospitalisations, healthy system capacity and mortality as well as transmission. Whilst also tracking the spread and evolution of COVID-19 to rapidly detect and characterise new variants of interest and concern, and calibrate public health and social measures, as well as our medical interventions and initiatives.

We continue to use whole-genome-sequencing to detect COVID-19 variants and have recently scaled up our capacity

61. To date, WGS (Whole Genome Sequencing) has been the primary method of detecting viral COVID-19 variants in international arrivals. Wastewater testing to determine the prevalence of variants in the wastewater at airports and airplanes is being explored but is not occurring yet. Wastewater testing at airports/airplanes would need to be validated as there are several differences between airport/airplane and municipal wastewater testing that may impact reliability and feasibility. Community variant monitoring is conducted via both individual testing and wastewater testing, and there is excellent agreement between the two metrics in terms of estimating the prevalence of variants. However, WGS of individuals can provide more detail of sub lineages, whereas for wastewater testing a bespoke assay for each variant is required for variant detection in wastewater and the genetic data is more fragmented in the wastewater compared to individual testing. Assays for wastewater testing can take time to obtain and validate, and genetic fragments in the wastewater may not be available in sufficient completeness to distinguish between sub lineages.

S9(2)(g)(i) [redacted]

S9(2)(g)(i) [redacted]

We are developing a national active surveillance initiative through surveys

62. Development is underway of both a COVID-19 infection prevalence survey and a COVID-19 seroprevalence survey. The surveys provide an opportunity to establish a national active surveillance initiative within New Zealand, gathering useful evidence to support short- and medium-term pandemic management and planning, and with potential to be adapted for other public health surveillance requirements in the future.

63. A key objective of the infection survey is to understand the 'true' prevalence of COVID-19 in the population, including people who may be infected but have no symptoms. The seroprevalence survey will add to knowledge about immunity against COVID-19 from prior infection or vaccination.

64. Design work for the infection survey is complete, and we are now in the advanced planning stage which includes testing public willingness to participate. Subject to approvals, the infection survey will move to a Pilot phase while design work for the seroprevalence survey is completed. It is anticipated both surveys will be fully implemented from October onwards.

65. Contracts for both wastewater and WGS cover the period from 1 July – 31 December. This has not yet been extended and is awaiting the development of a potential new agreement with ESR.

66. ESR are developing a procedure for wastewater testing at international airports as part of the wider wastewater-based epidemiology plan. This is still in development and

requires more work with regard to relationships with international airports, service providers for sampling and use of in-house genomics capability. Once fully developed, this will provide a 'first look' at what variants have entered the country at the border.

Case investigation and contact tracing

67. The case investigation and contact tracing system has evolved significantly since March 2020. Due to investment in case investigation capabilities, the system now has a sizeable and highly skilled workforce, and mature operating procedures, tools and systems, and knowledge.

68. Te Whatu Ora alongside Manatū Hauora continue to review case and household isolation periods and testing advice to ensure it remains proportionate, in line with evidence and modelling. We prioritise our case investigation caller capacity to ensure we deliver equitable outcomes. The prioritisation criteria is reviewed in light of changing case numbers to ensure that we are utilising our capacity appropriately.

69. The contact tracing system enablers and workforce capability remain available to support contact tracing activities as required.

70. Our baseline measures include:

- the delivery of the phone-based and electronic case investigations.
- the isolation of cases and household contacts
- the use of Bluetooth notifications
- guidance for cases to inform their contacts of exposure.

71. Our reserve measures include:

- push notifications
- quarantine and testing advice for close contacts.

72. Given the downscaling of response measures including removal of quarantine requirements for household contacts, significant public health rationale demonstrating proportionality would be required to reinstate these reserve measures, to justify the burden to wider society.

73. The self-management model that was employed as a result of the widespread Omicron outbreak has been effective and is likely to remain so in response to any emerging VoC. The utilisation of contact tracing resources will continue to provide the greatest benefit when prioritised for those with the greatest risk of adverse health outcomes.

74. Te Whatu Ora's National Investigation and Tracing Centre, within NPHS continues to review the use and benefit of digitally enabled tools for self-management of COVID-19.

NZ COVID Tracer App

75. In assessing the appropriate use of NZ COVID Tracer App in response to a VOC, consideration has been given to the following:

- any new emerging variant is likely to have a transmission advantage over previous variants, therefore efficient automated processes are required to aid the response

- ensuring the information provided via push notifications has a specific public health rationale, so as to justify reinstating the process and the burden on businesses and the wider public.

76. In light of this, we consider that Bluetooth functionality will continue to support the response as notifications are automated and settings can be adjusted to the characteristics of a new variant. This can be done without an App release.

77. While we still have the functionality to support push notifications, scanning and activating notifications requires a high-level of manual management, and its effectiveness is hinged on engagement with businesses to display posters, public willingness and social license to engage. Push notifications would be best utilised for very high-risk locations only, to avoid oversaturation of public messaging.

78. The NZ COVID Tracer App cannot currently be utilised for other communicable diseases due to the Apple and Google Terms of Use. These global contracts, spanning across jurisdictions, restrict data use to COVID-19.

79. On this basis, and taking into account the current funding and ongoing costs associated with maintenance of the NZ COVID Tracer, we recommend:

- to maintain the current functionality of the App in low maintenance mode (no further releases of the app and web application) until December 2022; and
- if QR code functionality hasn't been utilised by December 2022, to reduce the scope of the app to Bluetooth only, with a review of this in May 2023.

80. 9(2)(f)(iv) [redacted]

81. The service to generate QR code posters will be removed from the Official NZ COVID Tracer poster site on 29 September. This service can be reactivated as required to align with operational decisions regarding the use of the App. Te Whatu Ora maintains the ability to generate QR code posters on behalf of businesses, and this will be promoted on the webpage. This change was implemented to mitigate the security risk of running the service without active monitoring and maintenance.

Laboratories and diagnostics

82. Timely and accurate diagnostic testing for COVID-19 continues to be an essential part of our COVID-19 response strategy. Diagnostic testing supports both individual-level case finding and access to the clinical care pathway, and community-level actions to inform the overall public health response.

Testing infrastructure and supply

83. The current testing plan considers the potential for new variants to emerge, including the worst-case scenario of a highly transmissible (more than Omicron) and highly severe (worse than Delta) variant. From a testing perspective we need to continue to ensure there are sufficient RATs available to support widespread testing if required, and sufficient PCR capacity continues to be developed and maintained to ensure that capacity is available for our most clinically vulnerable and priority populations.

84. The latter required new contracting arrangement with laboratories, as current testing volumes have been considerably lower than the capacity that has been built. These contracting arrangements also need to consider the additional costs of ensuring border-

related positive PCR test samples are routinely and quickly transferred for whole genome sequencing to support variant surveillance.

85. Agreements have been developed with COVID-19 laboratory testing service suppliers from 1 August to 31 December 2022 with rights of renewal (for Te Whatu Ora – Health NZ) +6 months +6 months by negotiation. The agreements contain a consistent approach across suppliers for service levels, pricing, and commissioning.

86. Through the procurement exercise, we have established a consistent output across the laboratory network to retain a fixed capacity of 4,688 PCR tests per day until December 2022 – with the ability to surge to approximately 12,646 if required (single test).

87. The agreements contain a consistent approach across suppliers for service levels, pricing, and commissioning until 31 December 2022.

We are currently reviewing our testing guidance

88. Testing Guidance is currently under review with sector specific guidance focussed on Aged Residential Care and Community Residential Care facilities, Corrections, Testing Operational Guidance in General Practice and Supervised Rapid Antigen Testing Guidance for Community providers.

89. As part of the testing plan review and in context of other public health decisions, an assessment of alternative testing models and modalities for delivery for the COVID-19 end to end testing services will be considered. Testing requirements to support other response strategies (e.g.: VoC, isolation, borders), surveillance, and individual health needs with a focus on access and equity will inform the plan.

90. The review will also assess the need for more nucleic acid amplification tests (NAAT) point of care or near patient testing solutions as part of the wider health response and advice to general public and business on use in different contexts.

We continue to ensure we are delivering on our Equity Action Plan

91. Te Whatu Ora has developed a set of Advancing Equitable Access 8-point action plans that are situated within a Testing and Supply context. It is premised on 'Delivery Focused Strategy' and reviewed quarterly. The plans demonstrate 'equity in action' and sit within the Testing Strategy. The four key areas (Māori, Pacific, Disability and at-Risk Groups) are identified within the plan and focus on the ability to respond to immediate challenges as well as contributing to building community resilience for future outbreaks.

We are continuing to explore new technologies

92. Realtime multiplex device use is wide-spread across New Zealand hospital settings with increase throughout winter, to inform clinical management of those unwell with COVID-19 and other influenza like illnesses. Further exploration through the Testing Innovation Framework horizon scanning will identify new technologies for use in diagnostic and surveillance testing.

93. As part of operational planning across the five scenarios Manatū Hauora and DPMC are actively considering how innovative testing modalities could contribute to improving the effectiveness and efficiency of our COVID-19 response (including in relation to PDT requirements).

IPC and protection of the health and disability workforce

94. COVID-19 has confirmed the central role that IPC plays in the prevention and containment of outbreaks in health care facilities and in the community.

95. We have achieved tremendous improvements in IPC during the COVID-19 response to date, but more is needed to improve IPC. IPC focus has been mainly dedicated to the procurement of PPE, hand hygiene and cleaning supplies, and investing in the implementation of interventions to change practices.

IPC operational readiness and surge capacity

96. There is an urgent need to maintain IPC operational readiness and ensure surge capacity and the sustainability of IPC programmes in the long term. We have identified three major and enduring priorities.

97. First, it is essential that key improvements achieved during the pandemic be maintained.

98. Second, it is essential to strengthen and maintain IPC operational readiness for a resurgence of cases. If a resurgence is detected or anticipated, key immediate actions at national and health care facility level are required. Immediate steps at health facility level should include the reactivation of an incident command group for the coordination of IPC stakeholder networks and resource mobilisation, ensuring safe flow of patients and staff, ensuring safe care environment, ensuring personal protective equipment (PPE) availability and optimal use, vaccinating health workers as per latest protocols, increasing infrastructural capacity as required (e.g., triage and isolation capacity) and refresher IPC training. These actions will need to be contextualised for fragile, conflict or vulnerable settings.

99. Finally, after more than two years of focus on COVID-19, we need to take stock of lessons learned, make an in-depth situational analysis regarding IPC using standardised tools, and make plans to address further IPC priorities. It is essential to make health care facilities safer and more compassionate places through stronger IPC implementation, where family and visitors can be close to their loved ones during care and where our healthcare workers feel safe and protected from infection or disease.

Personal protective equipment

100. Since the start of the pandemic, Manatū Hauora and more recently Te Whatu Ora has managed the sourcing and distribution of PPE as part of the centralised nationally coordinated response. This approach has ensured the supply of PPE directly to identified groups that needed it and enabled more efficient stock management at a national level. Principles of Supply were developed to reflect government's policy settings and guide the distribution of PPE.

101. Throughout the pandemic, the customer base has significantly increased. This increase has aligned with the government's response to the pandemic and the continued widening of eligibility for publicly funded PPE.

102. While successful in the height of the pandemic to ensure equitable access to quality verifiable PPE items at a nationally purchased price, the current approach is unsustainable and no longer solely aligned with the COVID-19 health response. Te Whatu Ora will consider the future state of centralised national supply of PPE and critical medical supplies and plan a careful transition of its customers and suppliers towards a more fit for purpose distribution model.

103. Te Whatu Ora currently maintains the centralised national supply of PPE, intensive care unit (ICU) and respiratory equipment alongside critical medical items such as intravenous consumables, syringes and needles. Te Whatu Ora is confident it has good stocks of PPE available, for the next 12 weeks of stock based on forecast usage at medium pandemic volumes for high use items. Additional infusion pumps and ventilators have been provided through the national supply to localities for use over the winter months and as part of their pandemic readiness.

104. Te Whatu Ora will commence rolling back accessibility to publicly funded PPE. In shifting towards a more sustainable distribution model, Te Whatu Ora will provide recommendations on access and stage of an outbreak of response ensuring a readiness state of 12 weeks national stockpile is maintained. A rollback will align with public health measures and continue to support the remainder of the national response to the pandemic.

105. The roll back set to commence in late September is the first step in a phased approach to transitioning towards a future focused operating model and a reduction in costs associated with the supply and distribution of PPE.

106. Te Whatu Ora expect a minimum stock holding of 12 weeks at a medium distribution in order to respond to any changes in the system. Work will be undertaken as part of the transition to ensure critical services are set to ensure this can be achieved.

107. S9(2)(f)(iv)

108. [redacted]

We continue to support the expedition of the supply of critical medical items

109. Suppliers of medical devices and consumables have expressed concerns related to continuation of global logistics and supply chain constraints and access to warehousing capacity. There are currently over 140 critical medical supply items across vaccine, intravenous and respiratory consumables. Whilst a national stockpile exists, normal business access to supply is constrained.

110. Where possible government agencies are working collaboratively to expedite critical medical items to New Zealand and through ports domestically. Health sector suppliers and contract managers are working with the warehousing and logistics industry to reduce the risk of warehousing capacity not being available in times of higher demand for critical medical items, which have strict storage requirements.

Workforce

111. Continuity of the workforce is key to the functioning of the health system. Despite several initiatives being underway workforce remains a risk that requires ongoing management.

112. On 1 August 2022, the Minister of Health announced a suite of targeted measures to train more health workers domestically and bring more doctors and nurses into the county to help address immediate workforce pressures. These initiatives include:

    - streamlining and funding the system for international health workers, included doctors and nurses, to get their professional qualifications recognised in New Zealand.

    - expanding the Return to Nursing Support programme.

113. We are working across the various workforce pipeline programmes to map the areas where we may be able to traction to support a fast-track approach to meeting registration requirements. We aim to identify areas to work with relevant Regulatory Authorities to explore these opportunities. The work is aligned with Manatū Hauora and the team working on the Regulatory Authority reform.

114. The Aged Residential Care (ARC) workforce is currently considered to be at higher risk. Measures to help address this risk are improving rates of influenza vaccination, and assessing staff deployment and contingency plans as part of the Ministry of Health's overall winter preparedness work. The available resources and planning activity to date means that the ARC sector is relatively well prepared to manage the five variant scenarios, contingent on workforce being available to do so.

115. Our community led workforce through Care in Community Hubs capacity is critical to the success of COVID-19 wholistic health and social supports. Baseline capacity and capability and increasing this valuable skills pipeline for the health care workforce of the future will be a focus over the coming months. The current community led workforce within the Care in Community hubs target supports to our priority populations in areas such as vaccine, community led supports to testing, and kanohi ki te kanohi access alongside National Investigation and tracing Centre support to navigate information and communicate advice on testing, isolation and care access.

Case management, clinical operations and therapeutics

116. Ensuring safe and effective care for people with COVID-19 and its long-term effects requires strategic operational alignment of available evidence into guidance, and a strategic approach to assessment and management across the continuum of primary, emergency, critical, and rehabilitative care. Effective management of COVID-19 requires mechanisms for early recognition, triage and safe patient flow, and access to reliable diagnostics and timely resuscitation and treatment. Our health care systems must be ready to respond to the varying needs of people with mild, moderate, severe and critical disease, and to identify those suffering delayed consequences of infection, including those who may not have been diagnosed at the time of acute infection. Or those who don't have equitable access to appropriate and effective health services.

Care in the community is undertaking work to guide its programme through to June 2023

117. Care in the Community has been fundamental to reducing the impacts of COVID-19 on those who are more vulnerable. Care in the Community has established, and continues to establish, a novel model of locally led care including:

    - establishing and enabling more than 50 care coordination hubs to provide clinical and manaaki services in partnership with primary care and local organisations,

    - standing up the National Alternative Accommodation Service (NAAS) with MSD, MBIE and other agencies,

- streamlining welfare requests and referrals with MSD,
- developing and communicating national clinical guidance to the health sector,
- establishing a funding model and guidance for primary care,
- implementing a broad therapeutic access plan that enables pharmacists to supply and dispense COVID-19 antiviral medications and allows general practice to provide advance prescriptions,
- designing centralised digital and assisted systems for people to manage their COVID-19 care, and
- implementing routine and periodic programme monitoring for continuous quality improvement.

118. Care in the Community in its current form (and various related funding appropriations) is time limited until the self-isolation requirement ends. Planning is underway to transition programme functions provided through Care in the Community into Te Whatu Ora's localities-based care.

119. Te Whatu Ora has consulted with the hubs to determine what services should remain and transition into BAU activities. During the consultation, the Hubs identified the areas in which they have been successful in the supports provided to communities, and to deliver COVID-19 supports. This includes:

- addressing homelessness,
- mental health and addictions,
- long term conditions,
- child health (including childhood vaccination and immunisation programmes); and
- oral health.

120. The Hubs have reported that in order to address inequities within the health and welfare sectors, a flexible funding model is required. The Hubs have successfully engaged hard-to-reach groups and have supported a high number of individuals and whānau who have been otherwise 'invisible' or 'unreachable' to the health system.

121. The Ministry of Social Development (MSD) has arrangements in place with over 150 social service organisations (of which 70 are Whānau Ora providers) and over 225 food banks and other community food organisations to support those who are required to isolate due to COVID-19. MSD works in alignment with these groups through Community Connectors. S9(2)(f)(iv) [redacted]

122. Further information will be provided through the 27 September briefing in preparation for your meeting with the Minister of Finance.

Alternative accommodation (Self-isolation and Quarantine)

123. Alternative isolation accommodation (previously known as self-isolation and quarantine or SIQ) is managed by Te Whatu Ora and Ministry of Business, Innovation, and Employment (MBIE). Via Care Coordination Hubs, we determine eligibility for alternative accommodation and facilitate their placement. Currently, MBIE funds and procures the facilities into which people are placed through the NAAS. NAAS uses

business as usual accommodation systems and relationships with Orbit travel to book rooms and facilities for people who require a place to isolate safely. NAAS also has the ability to increase capacity to meet localised or national demand as required, by booking extra rooms at short notice – including as may be required while a National Quarantine Centre is being stood back up for purposes of isolating returnees should a new VoC necessitate this.

124. S9(2)(f)(iv) [redacted]

Māori and Pacific community-based workforce in Care in the Community

125. The COVID-19 Care in the Community response and success is reliant on the new and diverse community health workforce comprising a high proportion of Māori and Pacific community-based workers with a wide range of skills. This workforce was critical to the locally led response in Māori and Pacific communities especially reaching those who were previously not easy to access. These community health workforces have played, and will continue to play, an important role in supporting community resilience especially as Aotearoa moves through its next COVID-19 response and working to support whānau.

126. There is widespread support from the sector to recognise and retain this workforce for the immediate value they bring to the ongoing COVID-19 response and winter resilience as well as the longer-term value as a core health workforce to develop and grow. Retaining, developing, and growing the community health workforce will be a priority as we transition and evolve Care in the Community over the coming months.

Therapeutics

127. Care in the Community works closely with Pharmac to operationalise access criteria and implementation of expanded access for pharmacists to supply and dispense therapeutics.

128. The recent change to the access criteria for COVID-19 therapeutics will increase the proportion of the population eligible from approx. 10% to 20%. We continue to link our criteria for proactive initial assessment to this, because people will need an initial assessment to determine the suitability for providing therapeutics. General practitioners, registered nurses and pharmacists can now undertake an assessment for access.

129. This will increase demand on primary care from original projections, however it will still be a reduction from patient volumes experienced throughout winter. Most Primary Health Organisations have reported a range of between 50-90 percent of patients who were proactively contacted for an initial assessment over the winter period.

Strengthening essential health services and systems

130. We recognise that we need to be ready to scale up public health and social measures as the burden of COVID-19 increases to avoid preventable morbidity and mortality and reduce the risk of spread of the virus and therefore the emergence of new variants. Recognising that some public health and social measures, such as contact tracing and quarantine, are resource-intensive and disruptive, we have prioritised their use where they are most critical, such as amongst the most vulnerable, and we will continue to implement and support a risk-based approach that takes into consideration the benefits and risks of adjusting contact tracing and quarantine policies.

Hospital and intensive care capacity

131. The government has invested in increasing the physical capacity of hospitals to manage COVID-19 through a $100m investment in infrastructure. There has also been an investment of $544.2m (over four years) to increase the capacity and capability of critical care across the country. This investment will increase critical care beds by around thirty percent.

132. Te Whatu Ora monitors hospital activity on a daily, weekly and monthly basis, to understand the pressures and provide support as practicable. Regions are also taking a lead in developing regional solutions and initiatives to manage demand. Other monitoring includes availability of ventilators, PPE, pharmaceuticals and therapeutics central to the management of COVID-19 patients.

133. Hospitals continue to manage surge through redeployment of staff, deferring of planned care and increasing capacity where possible. A number of staff have also been upskilled to support trained critical care staff, in the event that capacity comes under pressure.

134. The hospital sector has managed the multiple demands of COVID-19 and other seasonal illnesses, together with optimising planned care delivery over the last two and a half years and this will continue to be the case. However, the sector needs to be supported with strong public health messaging aimed at minimising illness that may require hospitalisation, so that the system does not become overwhelmed.

135. Te Whatu Ora has introduced a seasonal pressures operating model to help the system mitigate COVID-19 and seasonal pressures (both in terms of demand and supply constraints such as staff sickness). The core components of this model include:

    - nationally consistent approach to escalation and action, coordinated at a regional level, to support delivery at district level
    - standardised escalation triggers and processes
    - priority actions for rapid delivery including:
        - enhanced community response – expanding telehealth support, expanding primary care and community radiology capacity, virtual support to ambulance services from hospital clinicians
        - supporting hospital flow – primary care support via telehealth as an option in EDs, more allied health and other capacity to support EDs and facilitate increased weekend discharge
        - support for Aged Residential Care – medical and nursing support via telehealth, staffing bureau approach to increase availability of nursing staff.

136. Rural hospitals have and continue to have plans to manage outbreaks in their communities. In general patients have only needed to be transferred to another facility when they needed a higher level of care. Maintaining a high level of support for people with COVID-19 in the community is key to managing the demand on smaller, isolated facilities.

National telehealth services

137. The National Telehealth Services (NTS) provide centrally coordinated national and local support for a wide range of programmes across the health sector and contribute

to the overall sector preparedness for VoC and other unplanned events that are likely to put pressure on the health system.

138. The funding needed to support the increased demand is supplemented through a range of COVID-19 programmes that are operating under the National Telehealth Services (NTS): The COVID-19 programmes supported under the NTS include COVID-19 Healthline, COVID-19 TO VAX line, Care in the Community, and Contact Tracing.

139. NTS work closely with NASO and Primary Care supporting the Winter Pressure Action Plan. This includes doctors providing "virtual" doctor assessments for those in COVID-19 self-isolation, delivery of antiviral prescriptions, and support for other clinicians (through the Clinical Advice Line). This has been further extended to the virtual doctor assessment service for ambulance paramedics to reduce transportation to ED for Level 3 and Level 4 patients. This programme is being rolled out nationally. There is sufficient funding available to 30 September 2022.

140. NTS works closely with Disability Support Services and Home Care to provide an escalation clinical pathway through a dedicated team and service design. S9(2)(f)(iv) [redacted]

141. S9(2)(f)(iv) [redacted]

142. S9(2)(f)(iv) [redacted] This will take place over this quarter when more information is known on policy settings and forecast case numbers. Contracts allow for this flexibility.

143. Mental Health and Addictions lines including 1737 Need to Talk are also operating at peak baseline levels and are expected to continue for the next few months. This increased demand is driven by increased volumes and complexity of calls.

Vaccination

144. The Strategy to Achieve Global Covid-19 Vaccination lays out the different goals of the COVID-19 vaccination programme with a priority to i) minimise deaths, severe disease and overall disease burden, and the impact on health systems, followed by ii) resume full socio-economic activity; and iii) reduce future risks, including the risk of new variants. Maintaining a Vaccine Strategy through the National Immunisation Programme remains at the forefront of our response to COVID-19.

145. Vaccines are proving less effective than hoped at reducing infection and transmission. Depending on age, schedule, and derivation of immunity, vaccines do have a modest impact on infection against the current dominant variant, Omicron. Despite this, and despite the high proportion of the global populations with infection-induced immunity, the global 70 percent vaccination target remains relevant especially when national programmes are designed to achieve that target through high vaccine coverage in high priority groups first.

146. As at 11 September, 91.5 percent of the Eligible population 12+ have received 1 dose of the COVID-19 vaccine, 90.2 percent Eligible population 12+ have received 2 doses.

147. There is sufficient supply of COVID-19 vaccines at this stage to support 2022 priorities (up to 6 million doses), including continuing to administer the paediatric course, additional immunocompromised doses, and provide booster 2 to priority populations.

We are currently developing our vaccine operating strategy beyond December 2022

148. The National Immunisation Programme (NIP) is currently developing its operating strategy beyond December 2022. Cabinet SWC paper SWC-22-MIN-005 on April 6 2022 noted that officials will report back in the second half of 2022 on how the vaccine programme is operating and the on-going COVID-19 NIP strategy. It was agreed that the current model being worked towards will maintain NIP capability to scale in the event of increased COVID-19 demands. Importantly the NIP COVID-19 strategic priority will be to focus on protecting those most at risk of the impacts of COVID-19 by enabling timely access to immunisations, with a particular focus on enabling Māori approaches. Overall, the operational model will give priority to Māori, Pacific peoples, people living with disabilities, seniors, tamariki, and other groups that experience inequities in COVID-19 outcomes.

149. The COVID-19 Immunisation Register (CIR) inventory functionality will be maintained into 2023, other relevant storage and delivery contracts are set to expire in December 2022, extension of these contracts is subject to the National Immunisation Programme's (NIP) future immunisation strategy report back due in the second half of 2022.

150. Existing Advance Purchase Agreements (APAs) can be leveraged to provide a route for additional volumes of vaccine for 2023 or early access to updated variant vaccines or expansion of vaccine eligibility to younger age groups. Currently scheduled deliveries are remaining Pfizer deliveries in 2022 and Novavax deliveries in 2022 and 2023; these include delivery options for potential new variant vaccines and vaccines for wider population groups such as under 5s. There is planning being undertaken to understand the value of additional purchasing agreements to maintain timely access to effective and sufficient vaccine supplies. Such work will be led by Pharmac and supported by NIP and the Public Health Authority (PHA), as all vaccine purchasing has been transferred to Pharmac as of July 2022. Officials across PHA, Te Whatu Ora and Te Aka Whai Ora will continue horizon scanning activities to maintain an understanding of the evolving COVID-19 vaccine landscape and align APAs with potential VoCs.

Settings are in place to manage any surge demand for vaccinators

151. While demand in the event of VoC outbreak may exceed that of the previous CVIP, there is capacity to recall the authorised provisional workforce. In addition, there are 2,198 provisional vaccinators without COVID-19 vaccines within their current authorisation who can be mobilised with training.

152. The Hands-Up pipeline for individuals interested in supporting the vaccinator workforce is still running. This means it would be possible to expand the provisional vaccinators unauthorised for COVID-19 vaccination as necessary. There is an additional 458 COVID-19 vaccinators working under supervision (CVWUS), 46 of which have completed the training to become a vaccinating health worker (VHW). The VHW is a recently established role intended to replace CVWUS and expanding their scope of vaccinations, including vaccinating 5-11s with the paediatric Pfizer vaccine. The VHW workforce will be able to vaccinate until their authorisation renewal in July 2024.

Risk communication, community engagement and infodemic management

153. To address the varied and dynamic COVID-19 situations, alongside competing public health priorities, we need to ensure our operational readiness for any COVID-19 scenario is in the context of inevitable concurrent events. Localised responses need to

be co-designed with communities to ensure relevance, acceptability, sustainability and effectiveness.

154. The first goal of infodemic management for COVID-19 is to understand the nature of the public conversation about the disease and the measures designed to protect against it. Targeted and consistent information across various media channels with good data and evidence continues to balance our response and social behaviours toward measures.

Improve COVID-19 health outcomes for priority populations and vulnerable communities

Māori

155. The COVID-19 outbreak has worsened the already inequitable health outcomes for Māori. As measures are stepped down, Manatū Hauora's Māori Protection Plan is critical; this plan is currently due to expire in December 2022. Related response measures are expected to continue to have a positive impact for Māori, including the ongoing mandatory measures.

156. We have some well-established baseline measures in place, including high vaccination rates. Across all ethnicities, 91.5 percent of people are at least partially vaccinated, and 73.2 percent of people eligible for first boosters have received them. For Māori, 86.7 percent of people are at least partially vaccinated and 56.3 percent of Māori eligible for first boosters have received them. While we have high vaccination rates for at least one dose, there is more work to be done in encouraging booster vaccination uptake among Māori.

Pacific peoples

157. Pacific peoples continue to be disproportionately affected by COVID-19 and continue to experience long-standing inequitable health outcomes and service use. Recent data shows proportionately Pacific peoples are most hospitalised for COVID-19 and their COVID-19 mortality rate is four time greater than European or other ethnicities.

158. 91.6 percent of Pacific peoples are at least partially vaccinated (compared to 91.5 percent across all ethnicities) and 61.1 percent of eligible Pacific peoples have received at least one booster dose (compared to 73.2 percent across all ethnicities). There is more work to be done in encouraging booster vaccination uptake among Pacific peoples.

159. The response to the Pandemic has highlighted the strengths of our Pacific communities and the capabilities of Pacific health providers to innovate and respond when supported appropriately.

160. Pacific health providers continue to face unprecedented demand and are delivering the full spectrum of response activities alongside uplifting the vaccination service and providing wraparound support, including for care in the community, to aiga and whanau.

161. These providers formed a key part of the Government's response to outbreaks under the COVID-19 Elimination Strategy and played a major role under the COVID-19 Protection Framework. The success of the ongoing response has been supported by these providers' ability to maintain the vastly enhanced scope of response activities compared to initially planned parameters.

Other groups

162. To ensure equitable and safe service coverage during COVID-19 events, a national approach to services has been agreed for Home Care Support Service (HCSS) clients

with HCSS providers and funders, Whaikaha – Ministry for Disabled People, ACC and Te Whatu Ora.

163. HCSS providers continue to use risk assessments to prioritise services with their clients to ensure essential cases are maintained. They are also prioritising referrals for essential cases (such as personal cares) and new requests for non-essential services such as housework are likely to be deferred or declined.

Financial considerations and constraints regarding our ongoing preparedness

164. 9(2)(f)(iv) [redacted]

Our ongoing health system response to Omicron has represented a cost beyond what we could have prepared for…

165. Sustaining baseline activities across our core enablers as part of our ongoing approach to COVID-19 represent an ongoing expense for the Government. Budget assumptions in December 2021 did not, and could not have, anticipated the impact Omicron has had on the public health response funding pool. Simultaneously, border openings and travel have increased the publics exposure to COVID-19 and influenza like illnesses since February 2022, which has also further increased spending on our health response.

166. S9(2)(f)(iv) [redacted]

S9(2)(f)(iv) [redacted]

170. Further advice will be provided to you on 22 September ahead of your meeting with the Minister of Finance on 26 September 2022.

Te Tiriti o Waitangi

171. The Crown's obligations to Māori under Te Tiriti o Waitangi require active protection of taonga and a commitment to partnership that includes good faith, engagement with, and appropriate knowledge of the views of iwi and Māori communities.

172. Engagement to date has highlighted that the current outbreak, and Government's response to it, have had a disproportionate impact on Māori. Māori are at higher risk of COVID-19 infection, hospitalisation, and death due to inequitable vaccination rates, incidence of pre-existing health conditions, and structural factors (e.g., housing deprivation). Māori service providers are therefore experiencing high workforce fatigue.

173. Our continued work across readiness and response will allow us to be more adaptable and target measures to the most vulnerable communities (e.g., strengthened guidance on testing in highly vulnerable places). Particular consideration of accessibility to tools that prevent risks of transmission or severe disease will be considered for iwi; an example of this is the increased availability of medical masks to marae, kaumatua facilities, and Māori vaccination providers.

174. Measures targeted at Māori continue to be necessary but have not been sufficient alone to create equitable health outcomes for Māori. We need to identify targeted measures and public health levers that will enable the Crown to meet its obligations under Te Tiriti o Waitangi and help reduce inequities in COVID-19 effects. The work of Te Aka Whai Ora with Kaupapa Māori providers is particularly key to realising this duty. Sector representatives reinforced the value of Kaupapa Māori providers in reducing inequities as they provided holistic support for whānau and had deeper reach than other providers. However, not all Māori have access or may not want to access Kaupapa Māori providers. Therefore, there needs to be a minimum level of cultural competency across the health workforce.

Next steps

175. We will continue to review our health system readiness to ensure we can quickly and efficiently respond to a VoC. As part of the routine PHRA a VoC assessment will be undertaken and operational levers will be assessed.

176. Te Whatu Ora will provide you with advice related to the continued forecast costs associated with maintaining baseline measures for the foreseeable future on 27 September 2022.

177. S9(2)(f)(iv) [redacted]