Regulatory Impact Statement: Proposed amendment to Self-Isolation Requirements Order 2022

Coversheet

Purpose of Document	
Decision sought:	*Analysis produced for the purpose of informing:* a proposed amendment to the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022
Advising agencies:	*Manatū Hauora – Ministry of Health* *Department of the Prime Minister and Cabinet*
Proposing Ministers:	*Minister for COVID-19 Response*
Date finalised:	*Friday 2 December 2022*

Problem Definition

Under the Bill of Rights Act 1990 (BORA) and the COVID-19 Public Health Response Act 2020 (the COVID-19 Act), the Government has a responsibility to ensure its response to the COVID-19 pandemic remains effective, justified and proportionate. Public health risk assessments (PHRAs) carried out on 7 November 2022 and 22 November 2022 considered whether any changes are required to current COVID-19 policy settings. The PHRAs were based on recent data about trends in the impact of the pandemic on the community, including data for deaths and hospitalisations, and modelling of possible future developments.

Executive Summary

- *What stakeholders and the general public think – are there any significant divergences in their views that should be brought to Ministers' attention?*

This Regulatory Impact Statement (RIS) sets out the information and analysis which informs proposed changes to the legal framework for managing the COVID-19 pandemic. The framework is established under the COVID-19 Act. Specific requirements are set out in the COVID-19 Public Health Response (Self-isolation Requirements) Order 2022 (the Self-isolation Order) and the COVID-19 Public Health Response (Masks) Order 2022 (the Masks Order), both of which are made under the COVID-19 Act.

The Self-isolation Order establishes the requirement that COVID-19 cases (cases) self-isolate. This requirement is qualified by provisions which enable cases to leave their place of self-isolation to carry out high priority activities under highly restrictive conditions. These conditions include strict infection prevention and control (IPC) measures.

The Masks Order establishes the requirement that people visiting healthcare services wear face masks.

The RIS draws on analysis including:

- information from the PHRA process
- detailed assessment of options against the criteria for the ongoing strategic approach

- Te Tiriti o Waitangi analysis, and Equity analysis.

The PHRA recommended that mandatory self-isolation for COVID-19 cases (cases) be retained. Isolation of cases remains the cornerstone of New Zealand's public health response to COVID-19. It significantly limits the transmission of COVID-19 by reducing the proportion of cases infecting others in the community. Further it was assessed that this measure is more effective than other less restrictive measures in combination. Specifically face masks or physical distancing are less effective while a shorter isolation period (with test to release) isn't considered a viable alternative.

Without government mandated isolation for cases, it is highly likely that adherence to guidance would be lower, resulting in an overall increase in transmission and case rates: increasing the risks of serious illness and hospitalisation for Māori, Pacific people, older people and people with disabilities (among other higher risk groups), and increasing pressures on the health system. Overseas evidence suggests that a legal requirement to isolate results in significantly greater adherence than a recommendation to isolate. Experience when other mandates (e.g., masks) have been removed in New Zealand suggests that adherence to guidance is typically much lower than to mandates.

s9(2)(g)(i)

[redacted]

Analysis presented in this RIS supports the recommendations of the PHRA.

Equity and Te Tiriti o Waitangi analysis support retaining mandatory self-isolation for cases. Health outcomes from COVID-19 for vulnerable populations, including Māori, remain disproportionately high by comparison with the wider population. Shifting from mandatory to voluntary self-isolation would be highly likely to result in an increase in the number of cases, with the consequence of a disproportionate negative impact on health outcomes for vulnerable populations.

Implementation, monitoring and review

Where changes are required, they are readily implementable through order changes and supporting public health initiatives.

The new measure would remain under regular monitoring and review, including through regular Public Health Risk Assessments.

Limitations and Constraints on Analysis

This proposal is subject to a number of limitations:

- limited time to prepare this Regulatory Impact Statement
- data from modelling results are subject to significant uncertainty around the impact of policy changes, the level of immunity in the population and population behaviour
- limited time for detailed equity and Te Tiriti o Waitangi analysis, and due to timeframes and sensitivity, wider engagement has not been possible. Current measures, which are recommended to be retained, have been engaged on in previous PHRAs.

- time constraints affecting the level of stakeholder engagement.

These limitations are acknowledged. However, the PHRA provides a robust process for consideration of proposed public health changes at pace. It draws on public health, policy, legal, operations and Māori health expertise, as well as detailed data and evidence. These sources are supported by further stakeholder engagement, primarily conducted by the Department of the Prime Minister and Cabinet (DPMC) and are set out in the Cabinet paper.

Responsible Manager(s) (completed by relevant manager)
Alice Hume *Head of Strategy and Policy* *COVID-19 Group* *Department of the Prime Minister and Cabinet*  *2 December 2022*
Stephen Glover *Group Manager, COVID-19 Policy* *Strategy, Policy and Legislation* *Manatū Hauora*  *2 December 2022*

Quality Assurance (completed by QA panel)	
Reviewing Agency:	Manatū Hauora
Panel Assessment & Comment:	The Ministry of Health's Papers and Regulatory Committee has reviewed the attached Regulatory Impact Statement and considers that it partially meets the quality assurance criteria. The analysis is complete and reasonably convincing, particularly in the multi-criteria analysis, however lacks clear Te Tiriti and equity analysis in the assessment of options. The document is difficult to read and there has been limited, insufficient consultation with Māori and other groups disproportionately affected by the pandemic.

Section 1: Diagnosing the policy problem

Context behind the policy problem

Under the BORA and the COVID-19 Act, the Government has a responsibility to ensure its response to the COVID-19 pandemic remains effective, justified and proportionate.

PHRAs carried out on 7 November 2022 and 22 November 2022 considered whether any changes are required to current COVID-19 policy settings. The measures in question are established by the Self-isolation Order and the Masks Order.

The PHRAs were based on recent data about the progress of the pandemic and modelling of likely future developments and on input from community sources.

How is the status quo expected to develop?

Overall, the key measures of COVID-19 infection (levels of viral RNA in wastewater and reported case rates) used to monitor the pandemic are stabilising, after substantially increasing since early October 2022.

Hospital admission rates increased over October 2022, while mortality counts have remained stable. However, in the past two weeks hospital admissions have also stabilised.

Experience to date shows that these measures tend to lag changes in infection rates. The current trends are likely to be influenced by a combination of:

i. waning immunity (vaccination and infection-induced immunity)
ii. behavioural changes associated with the relaxation of previous requirements, greater social interactions, and lower adherence with public health guidance
iii. the impact of new sub-variants.

It is likely that over the next few weeks, cases, hospitalisations and mortality could increase. However, the size, timing, and duration of the peak and new baseline trends of cases, hospitalisations and mortality is uncertain.
Australia is experiencing a wave of cases that may peak in the next few weeks. If New Zealand follows suit, as has occurred in the past and usually within a few weeks, we may see cases increase once more. However, there is significant uncertainty in predicting case and hospital trends.

What is the policy problem or opportunity?

What is the nature, scope, and scale of the problem?

In October 2022, Cabinet decided to retain Government-mandated seven-day isolation for cases and mask requirements for visitors to healthcare services. This decision was made in the context of emerging subvariants and rising case numbers, suggesting that New Zealand would likely experience a further wave by the end of 2022.

As noted above, there is significant uncertainty when predicting case and hospital trends. However, recent data and modelling suggests that there continues to be a realistic risk that we will see cases increase from November 2022 levels.

A further consideration is that we are approaching the summer holiday season. This will present particular challenges from the point of view of limiting the spread of COVID-19, as people leave their homes to go on holiday, in many cases to remote or rural locations.

The broad policy choice for the Government at present is whether strong guidance or government-mandated measures are the best way to encourage public health behaviour that

minimise the spread of the virus. Under the COVID-19 Act, public health advice must be considered in making this choice, but Ministers may also consider social, economic and other factors.

Based on preliminary analysis, the practical choices arising out of the November PHRAs have been narrowed down to the following:

* Retain the status quo of mandatory 7-day isolation for cases; or

* Retain the status quo and add a new permitted movement which would allow cases to travel home to isolate); or

* Remove mandatory isolation for cases and move to guidance only for cases.

s9(2)(g)(i)

[redacted]

Who are the stakeholders in this issue, what is the nature of their interest, and how are they affected? Outline which stakeholders share your view of the problem, which do not, and why. Have their views changed your understanding of the problem?

Stakeholders

The ongoing response to COVID-19 affects everyone in Aotearoa New Zealand. However certain groups are more at risk due to clinical or equity-based reasons (discussed further below). The response also requires ongoing support from business and communities to ensure the public health response remains effective. In seeking to remain proportionate, we continue to balance public health risk against the need to minimise any compulsory measures and any associated impost.

DPMC has carried out engagement based on draft public health advice with the Strategic Public Health Advisory Group, representatives from nine disability groups, members of the National Iwi Chairs Forum (NICF) and the Regional Leadership Groups (RLGs).

Public Health Risk Assessment

Officials from Whaikaha and Te Aka Whai Ora contributed the vulnerable group perspectives through the PHRA process. Officials were able to draw on community views in making representations over the course of the PHRA.

s9(2)(g)(i) [redacted]

Iwi Māori leaders reported local resistance to mandated requirements, and NICF and iwi Māori leaders suggested that well communicated guidelines may be more effective. NICF members stressed the importance of communication being simple, clear and straightforward to whānau and led by Māori where possible.

Regional Leadership Groups (RLGs)

Regional Leadership Groups (RLGs) are 12 regional groups across the country comprising community leaders such as iwi, local govt (Mayors and/or Council chief executives), other community leaders eg Chamber of Commerce chief executives. RLGs provide a regional voice on COVID-19 issues. Regional Public Service Commissioners and other regional public service leaders attend this group to collaborate and coordinate on regional priorities.

RLGs had mixed views on retaining or reducing case isolation though broadly supported retaining seven-day isolation for people with COVID-19. Regional leaders provided split feedback, with the business community noting likely compliance challenges for infected visitors over summer and more broadly raising the possibility for a transition to an endemic management approach; while Iwi, community, government (central and local) leaders largely support the status quo or expanding it, emphasizing people's ongoing clinical or employment vulnerability or health system capacity concerns.

RLGs noted that COVID cases, hospitalisations, and deaths are increasing, with a possibility of a spike in cases over summer as people begin to travel inter-regionally. Continuing mandatory self-isolation requirements could help to reduce the spread, and reduce the burden on hospital and regional medical services who are stretched, or may have reduced to skeleton staff over the holiday period particularly in popular holiday destinations like Te Tai Tokerau and Queenstown Lakes.

RLGs have advised that some small business owners report that staffing shortages due to staff being unwell, isolating and unable to work, particularly within the hospitality industry remains a concern. Otago and Southland RLGs report that the tourism sector has concerns around travellers who test COVID positive that may be unable to self-isolate in place. It is understood that some accommodation and transport providers have expressed a reluctance to support travellers who become unwell with COVID-19 while travelling.

However, RLGs also note negative community attitudes, public apathy and pushback to remaining restrictions. Some RLGs provided anecdotal evidence that there is local resistance to existing restrictions in place, with some people reluctant to test and to self-isolate as it will impact their ability to operate their businesses.

If cases are no longer required to isolate, RLGs suggested that guidance could be provided to encourage those who are unwell to test and stay home if positive on a voluntary basis. Some regional leaders expressed that, as COVID-19 become endemic, people need to take their own preventative measures, suggesting a removal of government-mandated measures. Any removal of mandatory measures should be accompanied by guidance on voluntary, protective measures and good public health behaviour, as well as information about the level of risk so people can be well-informed in making their own decisions.

Transport

s9(2)(g)(i) [redacted]

Vulnerable populations

The burden of COVID-19 does not fall equally, and changes to protection measures could disproportionately affect population groups such as older people, disabled people and tāngata whaikaha Māori, Māori, Pacific peoples and some ethnic communities. At a high level, population agencies have noted that

- retaining public health measures aimed at limiting the spread of COVID (such as masking or self-isolation requirements) will benefit older New Zealanders. Case isolation requirements remain the most effective measure to reducing transmission of COVID-19 and therefore reducing inequities.
- disabled people and tāngata whaikaha Māori have experienced an exacerbation of existing inequities throughout the COVID-19 pandemic. Retaining mandatory self-isolation provides protection for disabled people and give disabled people the confidence to participate in activities outside their home.
- continued self-isolation requirements alongside other supports for Māori including access to sick leave and sanitation supplies to prevent further transmission in households.
- retaining self-isolation aligns with their strategic priority, Pacific Aotearoa Lalanga Fou Goal 3: Resilient Health Communities.
- any changes need to consider the individual needs of whānau who are engaged in the Corrections and wider justice systems.

Does this problem disproportionately affect any population groups? eg, Māori (as individuals, iwi, hapū, and whānau), children, seniors, people with disabilities, women, people who are gender diverse, Pacific peoples, veterans, rural communities, ethnic communities, etc.

Across the health system, Māori and Pacific peoples are more at risk of negative health outcomes than other population groups on an age-comparable basis, and are also more likely to experience greater disease exposure. Similarly, those experiencing socio-economic disadvantage are at greater risk of severe negative health outcomes than other people of the same age, and are also more likely to experience greater disease exposure.[1]

COVID-19 is no exception to these disparities. The burden of COVID-19 does not fall equally, and some people are at higher risk of adverse health outcomes from the virus.

Are there any special factors involved in the problem? e.g, obligations in relation to Te Tiriti o Waitangi, human rights issues, constitutional issues, etc.

Given the broad implications of COVID-19 requirements and consistent with the requirements in the COVID-19 Public Health Response Act 2020, we need to consider public health implications, BORA implications and Te Tiriti o Waitangi and equity implications.

s9(2)(h) [redacted]

[1] These statements are supported by the *Health System Indicators framework: Measuring how well the health and disability system serves New Zealanders* last updated 15/06/2022,

s9(2)(h)

[redacted]

[redacted]

Outline the key assumptions underlying your understanding of the problem

The key assumptions underlying the approach to the problem taken in this RIS:

- The Government has a legal responsibility to manage the response to COVID-19, within the framework established by the COVID-19 Act and BORA considerations.
- The Government has a legal responsibility to ensure that the response to the pandemic is effective, justified and proportionate.
- In carrying out its legal responsibility, the Government must take account of public health advice, and may take account of other relevant social and economic considerations.

What objectives are sought in relation to the policy problem?

We are seeking a response that is consistent with the overall objectives of the strategic approach and fulfils key health objectives.

The overall objectives are:

- **Prepared** means we are prepared to respond to new variants with appropriate measures when required. This includes having the measures in place, including surveillance, to know when and how we might need to respond.
- **Protective and resilient** means we continue to build resilience into the system, and continue both population and targeted protective measures. We take measures as part of our baseline that reduce the impact on individuals, families, whānau, communities, businesses, and the healthcare system that will make us more resilient to further waves of COVID-19.
- **Stable** means our default approach is to use as few rights and economy limiting measures as possible. As part of our baseline there are no broad-based legal restrictions on people or business, and no fluctuating levels of response to adapt to.

Section 2: Deciding upon an option to address the policy problem

What criteria will be used to compare options to the status quo?

Consistent with the requirements in the COVID-19 Act, and other related requirements, we have identified the following criteria.

Proportionality as required by the COVID-19 Act - the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds BORA considerations (thereby informing the legal basis for the measures considered).

Economic and social impact - evidence of the effects of the measures on the economy and society more broadly

Equity - Evidence of the impacts of the measures for at risk populations

Compliance - expected public compliance with measures (noting that this would only be used where compliance is relevant - not where there is a mandated requirement to fulfil e.g vaccination for health care workers, or information provision from new arrivals).

These criteria are aligned to the criteria for the new strategic approach. We note that implementation considerations are being considered separately, in Section 3 below.

What scope will options be considered within?

Options are considered within the scope of:

a) The Government's responsibility to manage the response to COVID-19, within the framework established by the COVID-19 Act (including BORA considerations).
b) The current context of the pandemic, as identified by public health analysis and advice.
c) Other social and economic considerations relevant to the Government's response to COVID-19.
d) The current legislative framework for the Government's response to COVID-19, although modifying the framework remains an option.

Analysing the proposals

Proposals for different options for each of the measures considered are included below, together with analysis, including public health advice and multi-criteria assessment.

The key for the multi-criteria assessment is as follows:

The proposals are withheld in full under section 9(2)(f)(iv) of the Act

Key for qualitative judgements:	
+	better than doing nothing/the status quo/counterfactual
+/-	about the same as doing nothing/the status quo/counterfactual
-	worse than doing nothing/the status quo/counterfactual

Equity analysis

The burden of COVID-19 does not fall equally, and some people are at higher risk of adverse health outcomes from the virus. Priority populations such as Māori, Pacific peoples, older people, disabled people and tāngata whaikaha Māori, and some ethnic communities experience disproportionate impacts of COVID-19 by way of:

- the effects of the virus, for example for those with co-morbidities
- the impact of public health measures on the ability to exercise choice, for example, about carers
- the impact of public health measures on economic stability, for example being unable to afford to take the necessary time of work to isolate or quarantine, or the risk time off creates regarding job security
- the impacts of existing systems relied upon to implement some of the measures in place to manage COVID-19, such as the use of penalties non-compliance with certain COVID-19 Orders and the inability to pay these forging a pathway into the criminal justice system.

Reducing mandated public health measures may lessen the impact of public health measures on choice, economic stability and experience of inequity due to enforcement systems. However, it has the potential to increase the inequity associated with co-morbidities or other health conditions that exacerbate the effect of contracting the virus, for example leading to self-imposed isolation, or an increased chance of hospitalisation or needing medical intervention.

An initial assessment of impacts and opportunities of the new strategy for priority populations is set out below.

Due to time constraints, further comprehensive consultation has not been completed with Māori and Pacific Peoples to inform the equity analysis.

Equity analysis for Māori

The COVID-19 outbreak has worsened already inequitable health outcomes experienced by Māori. The mandatory measures in place have sought to minimise and protect priority populations from COVID-19.

Among Māori, 86.8 percent are at least partially vaccinated, and 56.3 percent of Māori who are eligible for first boosters have received them. While there are high vaccination rates for at least one dose, booster vaccination uptake could be improved among Māori. 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.

Māori continue to have the one of the highest hospitalisation rates compared to other ethnicities, after standardising by age. COVID-19 attributed mortality rates are also higher 1.9 times higher among Māori, compared to European and other ethnicities. Modelling predicts that the mid-December 2022 peak will see 1800 daily new cases among Māori. It also indicates that during the peak there may be 30 Māori hospital admissions per day.

Equity analysis for Pacific peoples

Pacific Peoples continue to be disproportionately affected by COVID-19 in addition to long-standing inequitable health outcomes and service use. Recent data shows that Pacific Peoples are significantly overrepresented in all of the negative COVID-19 health statistics.

Among Pacific Peoples, 91.7 percent are at least partially vaccinated (compared to 91.5 percent across all ethnicities) and 61.2 percent of eligible Pacific peoples have received at

least one booster dose (compared to 73.1 percent across all ethnicities). There is more work to be done in encouraging booster vaccination uptake among Pacific peoples to mitigate the impact of the predicted rise in case numbers over the summer.

Pacific peoples continue to have the highest hospitalisation rate compared to other ethnicities, after standardising by age. In the week ending 23 October 2022, age-standardised rates for hospitalisation for COVID-19 decreased for all ethnicities except Pacific peoples. COVID-19 attributed mortality rates are also 2.4 times higher among Pasifika, when compared to European and other ethnicities.

Modelling predicts that the mid-December 2022 peak will see 800-900 daily new cases among Pacific Peoples. It also indicates that during the peak there may be 15 Pacific Peoples hospital admissions per day.

Equity analysis for older people

Older people are more likely to be hospitalised and this is reflected in the latest data. As the virus takes longer to move through this population due to this group having fewer social interactions, it may lead to a higher hospitalisation burden over a longer period beyond winter. Opting to remove mandatory case self-isolation will cause lasting health issues and death for older people who fall ill due to the increased transmission resulting from cases ignoring self-isolation guidance. Opting against reinstating mask requirements on public transport will impact on the health of those amongst this group, particularly as many older people rely on public transport for essential travel.

Equity analysis for disabled people and tāngata whaikaha Māori

The Human Rights Commission's report Inquiry into the Support of Disabled People and Whanau during Omicron found that lessening restrictions led some disabled people to choose to isolate themselves, leading to feelings of isolation and stress and a restriction on their own freedoms for the benefits of others.

s9(2)(f)(iv)

The continuation of measures, particularly face masks requirements for people accessing medical services, provides people with disabilities some, albeit little, reassurance. The absence of mask requirements in environments such as public transport causes anxiety and additional risk for disabled people, particularly those with underlying co-morbidities.

Equity analysis for other/all groups

The most deprived populations continue to have the highest rates of hospitalisation, and have twice the risk of hospitalisation, compared with those who are least deprived. Those who live in crowded housing, especially Māori, Pacific peoples, and some ethnic communities for example, living in an intergenerational arrangement, or those who work in particular roles such as hospitality or retail, are also likely to be more at risk of transmission.

Broadening the essential permitted movement of cases to allow them to return to their primary place of residence will enable cases visiting family living in crowded housing to return home to isolate and protect their vulnerable family members. It also eases the monetary burden on those who are most deprived who would otherwise be forced to pay for additional accommodation so that they can complete their self-isolation in situ.

Retaining the 7-day self-isolation period ensures that cases belonging to vulnerable groups, who may otherwise face pressure or coercion from their employers to return to work, can refer to the mandated self-isolation period as a reason they cannot leave isolation. This allows them to rest and recover, which reduces the immediate and long-term health impacts of their infection. It also prevents the case from infecting family, friends and colleagues, who may also belong to vulnerable groups. On the other hand, there are some equity concerns that retaining mandated 7-day isolation prevents people in high-deprivation from returning to work and earning money, and further, that this may jeopardise their employment.

Removing mandatory case self-isolation and switching to isolation guidance only would result in much lower compliance with self-isolation advice. Long-term COVID-19 sequelae and Long COVID, which disproportionately impacts vulnerable groups such as Māori, Pacific Peoples and people with disabilities, would increase as cases do not rest and recover when they are ill. Transmission would increase, putting vulnerable populations at even greater risk than they face under the status quo settings. Removing mandatory self-isolation, however, represents a significant reduction of rights-limiting measures imposed on cases, but in the current context these limitations are justified.

Te Tiriti analysis

Demonstrating a commitment to and embedding the Te Tiriti and achieving Māori health equity remain a key COVID-19 health response priority. The COVID-19 outbreak has worsened the already inequitable health outcomes for Māori.

In December 2021, the Waitangi Tribunal's Haumaru: COVID-19 Priority Report states that Te Tiriti obliges the Crown to commit to achieving equitable health outcomes for Māori, and that doing so only along with commitments regarding other ethnicities is insufficient; specific focus must be granted to achieving equitable outcomes for Māori. The report found that the Government was failing to meet Te Tiriti obligations, in particular with the rollout of the vaccinations programme, and that this failure would result in disproportionate and lasting impacts of Long COVID on Māori.

As Māori continue to be overrepresented among daily cases, and modelling predicts 1800 daily new cases among Māori during the mid-December peak, the Māori Protection Plan's two key drivers are critical. Response initiatives should continue to have a positive impact for Māori, including the ongoing Winter Package measures. This includes as free medical and N95 masks, greater access to antivirals for those that are eligible by prioritising equitable access for Māori alongside other eligibility criteria, and COVID-19 and flu vaccinations.

Targeted engagement has been undertaken with Māori stakeholders on the changes being assessed in this regulatory impact statement: with the National Iwi Charis Forum, representatives of non-affiliated iwi and Māori leaders who are part of RLGs. In addition, Māori health representatives taking part in the 22 November 2022 PHRA expressed strong support for each of the changes assessed in this regulatory impact statement. This excludes the proposed removal of mandatory case self-isolation, as this was not discussed in the PHRA. They noted that while expanding essential permitted movements for cases may increase transmission, which disproportionately impacts Māori, it would also allow Māori to access the goods that they require in order to isolate safely. s9(2)(g)(i) [redacted]

s9(2)(g)(i)

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 health inequity resulting from COVID-19. The work of Te Aka Whai Ora with Kaupapa Māori providers is particularly key to realising this duty. NICF members and disability 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.

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

The overall assessment arrived at through the analysis presented in this RIS supports the following recommendations:

a) Retain mandatory self-isolation for COVID-19 cases.
b) COVID-19 cases who become infected while travelling should be permitted to return to their home or primary residence.

Section 3: Delivering an option

How will the new arrangements be implemented?

Introducing a new permitted movement would require an amendment to the Self-isolation Order.

Clear communications on the change would be supported through the use of the Unite Against COVID-19 channels, targeted information campaigns, and by supporting announcements on these changes.

Further consultation will be completed on the self-isolation proposal, particularly with priority population groups to understand their perspectives.

Changes to policy settings would also have direct impacts on the quantum of funding required to deliver the associated activities. It is noted that a separate paper addressing the funding required to deliver these settings, and related health services, is due to be considered as a companion to the Cabinet paper to which this RIS relates.

How will the new arrangements be monitored, evaluated, and reviewed?

As noted above, the Government is required under the COVID-19 Act to monitor and review mandatory public health measures. This includes monitoring of case numbers, hospitalisations, international trends to identify variants of concern, along with wastewater and other surveillance activities. Trends in case numbers, hospitalisations and mortalities are compared by ethnicity and deprivation. The results of this monitoring and surveillance is compiled into a weekly insights report (as well as other ad hoc reporting) to help inform decision making.

A further PHRA is planned for January 2023. The Minister for COVID-19 Response will report to Cabinet on the results of that review and any proposed changes to settings.