Regulatory Impact Statement: Review of Public Health Measures to support the future of the COVID-19 Protection Framework and moving to the new strategy

Coversheet

Purpose of Document	
Decision sought:	*Analysis produced for the purpose of informing: final Cabinet decisions on the removal of the COVID-19 Public Health Response (Protection Framework) Order 2021*
Advising agencies:	*Manatū Hauora-The Ministry of Health and Department of Prime Minister and Cabinet*
Proposing Ministers:	*The Minister for COVID-19 Response*
Date finalised:	*29 August 2022*

Problem Definition

The COVID-19 context is currently changing, given the recent reduction in case numbers and hospitalisations, as well as moving to a new strategic approach to managing the pandemic.

Given this context, the Ministry of Health has reviewed the legislative framework in the Orders that sit under the COVID-19 Public Health Response Act 2020 for the ongoing management of the public health response. This is to ensure the response remains effective, justifiable and proportionate under the Bill of Rights Act 1990. In particular, the measures that were considered are:

1. the COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand
2. the post-arrival testing requirement for arrivals to New Zealand
3. the requirement for air travellers to New Zealand to provide information for contact tracing purposes prior to departure
4. the requirement for travellers to New Zealand not to exhibit symptoms or be under a public health direction
5. the requirement for household contacts to quarantine for 7 days
6. the 7-day case isolation requirement
7. the COVID-19 Public Health Response (Vaccinations) Order 2021 which includes the vaccination mandates for health and disability sector workers
8. the current masking settings, that require mask use when travelling on a range of transport options, in public venues, health care settings and retail settings among other places.

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 Assessment Statement provides details on the policy analysis and public health review to inform a number of changes to the legal framework for managing the ongoing COVID-19 Pandemic.

This review has focussed on the legal requirements or mandates currently prescribed in the Orders under the COVID-19 Public Health Response Act 2020. This is timely as these changes will inform the ongoing strategic approach for the public health response to COVID-19 as we look to move away from the COVID-19 Protection Framework.

To ensure the proposals are effective, justifiable and proportionate under the Bill of Rights Act, consistent with the requirements in the COVID-19 Public Health Response Act 2020, we have drawn on analysis including:

- information from the Public Health Risk Assessment process
- detailed assessment of options against the criteria for the ongoing strategic approach
- Te Tiriti o Waitangi analysis, and Equity analysis.

Based on an overall assessment, we support the recommendations of the Public Health Risk Assessment to:

a. remove the post-arrival testing requirement for all arrivals to New Zealand and replace it with other targeted surveillance and information provision measures for travellers

b. remove the COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand (including for air crew)

c. retain the requirement for air travellers to New Zealand to provide information for contact tracing purposes prior to departure

d. remove the requirement for household contacts to quarantine for 7 days, and replace it with guidance to test daily for five days, pending the outcome of wider consultation

e. maintain the current 7-day case isolation requirement

f. revoke the COVID-19 Public Health Response (Vaccinations) Order 2021 and remove the remaining vaccination mandates for health and disability sector workers

g. retaining masks requirements on public transport and healthcare settings (including aged residential care)

Where changes are required, they are readily implementable through order changes and supporting public health initiatives. Consideration has been given to whether these changes can be re-instated if required for future variants of concern and this will be possible.

The public health measures will remain under regular monitoring and review, including through regular Public Health Risk Assessments. Given condensed timeframes, further work is required to develop an appropriate evaluation framework and methodology.

Limitations and Constraints on Analysis

This proposal is subject to a number of limitations:

- Limited time to prepare this Regulatory Impact Statement
- Limited data available on the impact of the proposals given the fluid nature of the COVID-19 response

- Limited time for detailed equity and Te Tiriti o Waitangi analysis, and due to timeframes and sensitivity, wider engagement has not been possible.
- Limited stakeholder engagement.

While these limitations are present, the use of the Public Health Risk Assessment involving public health, policy, legal, operations and Māori health expertise and drawing on detailed data and evidence provides a robust process for consideration of public health changes at pace. This has been supported by further stakeholder engagement, primarily conducted by DPMC.

Responsible Manager(s) (completed by relevant manager)

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29/08/2022

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Quality Assurance (completed by QA panel)

Reviewing Agency:	Ministry of Health
Panel Assessment & Comment:	The Ministry of Health's Papers and Regulatory Committee has reviewed the attached Impact Assessment and considers it partially meets the quality assessment criteria. The analysis is reasonably convincing. It focuses on proportionality, and largely relies on the Public Health Risk Assessment (an internal workshop with a wide range of public health, policy and legal expertise), which is reasonable given the time constraints. The proposals have not been widely consulted upon, though this is mitigated to some extent by engagement with, in particular, the Iwi Chairs Forum, and future engagement planned. Effects on equity are unclear and should be very closely monitored.

Section 1: Diagnosing the policy problem

What is the context behind the policy problem and how is the status quo expected to develop?

New Zealand's Elimination Strategy, and then the COVID-19 Protection Framework's (CPF) minimisation and protection approach since December 2021, have been successful in limiting the worst impacts of COVID-19. This has been achieved by adapting our response to the specific features of each COVID-19 outbreak and the availability of public health responses at the time (e.g. effective vaccination).

By all measures New Zealand's current COVID-19 outbreak is waning, with reducing case numbers, hospitalisations, and deaths. Modelling suggests this trend should continue for some time. However, it is still unclear when the outbreak will plateau.

The most likely medium-term COVID-19 outlook for New Zealand suggests waves of COVID-19 infection and reinfection, as seen internationally. However, the actual trajectory and severity of future outbreaks remains uncertain due to the likelihood of new variants of concern. As the COVID-19 pandemic continues to evolve, the legal Orders that give effect to the Government's COVID-19 response have been under active review to ensure they provide an effective public health response, and to ensure that the measures remain proportionate in terms of the Bill of Rights Act.

In July 2022, reflecting the changing outbreak context and limitation of the CPF, Cabinet agreed to shift to a new strategy for managing COVID-19 after winter 2022 [CAB-22-MIN-0251]. Going forward, we will be using a strategic approach with increased flexibility that can respond to new variants of concern as they emerge, while also providing the flexibility to manage with lower case numbers if they continue to decrease.

To give effect to the new strategy, Cabinet agreed that an approach of relying on baseline measures will be used, with more restrictive reserve measures used as guided by public health advice.

Baseline measures will cumulatively help to ensure the burden on the health system is minimised, our communities are strengthened, and those who feel vulnerable feel safe and are less at risk of infection or poor outcomes from COVID-19. These measures largely move away from mandatory requirements, and instead rely on voluntary uptake, increasing the overall stability of our response as they are not subject to ongoing changes to the legislative framework. Baseline measures can be in place at any time and be scaled as required. Examples include maximising population immunity through vaccination, investment in the healthcare system, anti-viral therapeutics, and surveillance testing. These measures may be here to stay as part of our long-term management of COVID-19.

Most reserve measures are rights limiting. They rely on powers triggered in particular circumstances (e.g., an epidemic notice) and involve a more acute trade-off between limiting transmission, economic impacts and impacts on people's rights. These measures would be used if proportionate to do so, guided by public health advice. These may include vaccination requirements, mask requirements, gathering limits, movement restrictions, and border measures.

The current use of reserve measures was considered as part of the Public Health Risk Assessment process, which has been the standard process for providing public health advice to manage the ongoing pandemic. The Public Health Risk Assessment is a formal discussion involving public health, clinical and scientific expertise that draws on detailed data, evidence and provides a robust process for consideration of public health changes at pace.

This Regulatory Impact Statement reviews the proposals from the Public Health Risk Assessment, particularly in terms of the proportionality under the Bill of Rights Act, equity and Te Tiriti o Waitangi implications, as well as the broader impact of the proposals.

What is the policy problem or opportunity?

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

The COVID-19 context is changing, given the recent reduction in case numbers and hospitalisations, as well as moving to a new strategic approach to managing the pandemic.

Given this context, the Ministry of Health has reviewed the legislative framework in the Orders that sit under the COVID-19 Public Health Response Act 2020 for the ongoing management of the public health response. This is to ensure the response remains effective, justifiable and proportionate under the Bill of Rights Act 1990. In particular, the measures that were considered are:

1. the COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand
2. the post-arrival testing requirement for arrivals to New Zealand
3. the requirement for air travellers to New Zealand to provide information for contact tracing purposes prior to departure
4. the requirement for travellers to New Zealand not to exhibit symptoms or be under a public health direction
5. the requirement for household contacts to quarantine for 7 days
6. the 7-day case isolation requirement
7. the COVID-19 Public Health Response (Vaccinations) Order 2021 which includes the vaccination mandates for health and disability sector workers
8. the current masking settings, that require mask use when travelling on a range of transport options, in public venues, health care settings and retail settings among other places.

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?

The ongoing response to COVID-19 effects everyone in Aotearoa New Zealand, however certain groups are more at risk due to clinical or equity-based reasons (and this is explored 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, and members of the National Iwi Chairs Forum (NICF). Recent updates to advice on masks and household contact testing have not been discussed with external groups. Further engagement with NICF members is planned for 31 August and Te Rōpū Whakakaupao Urutā the same week, date TBC, and with Iwi not affiliated to the NICF and Māori Organisations on Thursday 1st of September.

The Strategic Public Health Advisory Group discussed the relative benefits of mandatory measures and guidance. Their experience was different for different measures depending on

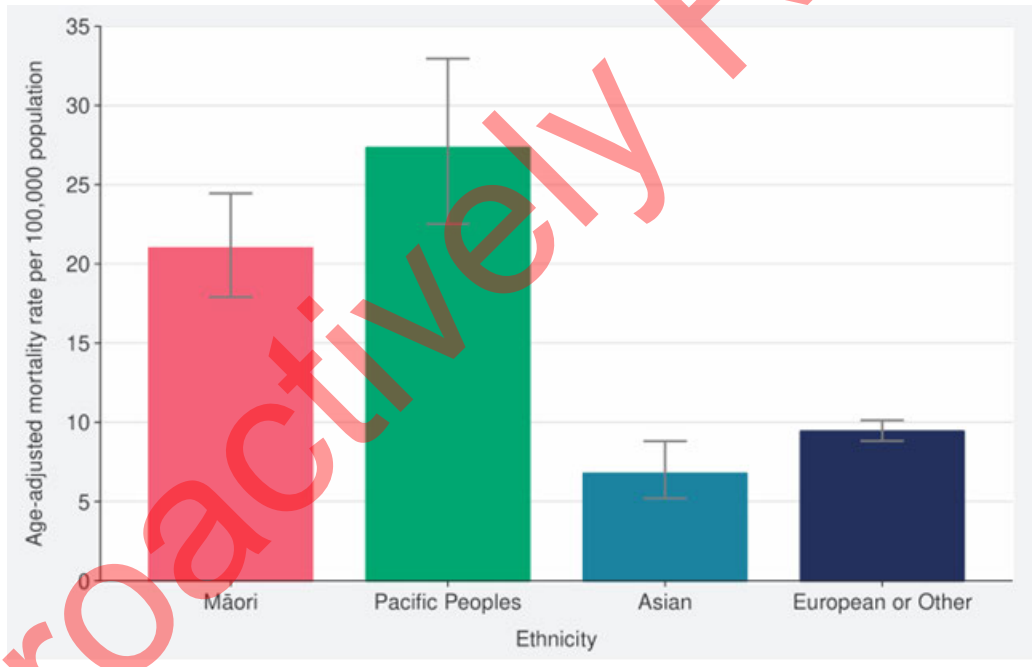
whether New Zealand in a crisis or not. Their general message was there is a need to transition away from broad mandates to more normal public health arrangements for COVID-19 and to keep the bar high for the use of broad mandatory measures. They consider there is a lot of confusion about what current measures are, given frequent changes. They also considered that support for economically vulnerable people to stay home when sick should be an important baseline measure.

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.

The burden of COVID-19 does not fall equally, and some people are at higher risk of adverse health outcomes from the virus.

Analysis undertaken to assess hospitalisation risk from COVID-19 has found that disparities in hospitalisation risk by ethnicity, deprivation and vaccination are clearly observed after adjusting (age-standardising) for differences in age demographics. Pacific Peoples had the highest cumulative incidence rate of hospitalisation with COVID-19, which was 1.4 times higher than Māori ethnicity, 3.4 times higher than European or Other ethnicity and 3.6 times higher than Asian Peoples (see Figure 3 below).

Figure 3 - Age-standardised cumulative incidence (and 95% confidence intervals) of hospitalisation with COVID-19 by ethnicity, March 2020 to 14 August 2022



Similarly, for total COVID-19 attributed mortality rates by ethnicity, Pacific Peoples had the highest rate which was 1.4 times higher than Māori ethnicity, 3.1 times higher than European or Other ethnicity and 4.2 times higher than Asian ethnicity.

That is why the baseline measures include targeted protections for the most vulnerable. For example, in the winter package there was expanded access to antivirals, particularly for people at significant risk of adverse health outcomes from COVID-19. These measures included increased availability of medical masks, including to Pacific churches, marae, kaumatua facilities, aged residential care (ARC), and Māori and Pacific vaccination providers.

Increases in the risk of health impacts of COVID-19 could disproportionately affect populations groups such as older people, disabled people, Māori, Pacific peoples, and some ethnic communities.

We have provided more detailed equity analysis in the 'analysing the proposals' section.

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 the COVID-19 Protection Framework, and consistent with the requirements in the COVID-19 Public Health Response Act 2020, we need to consider Public Health Implications, Bill of Rights Act Implications and Te Tiriti o Waitangi and Equity Implications.

Public Health advice:

These proposals are informed by the Public Health Risk Assessment process, and the summary findings from the PHRA are noted in the analysis. The intention in this RIS is not to review the public health analysis, but to consider the other factors that inform the regulatory process.

Bill of Rights Act implications:

s9(2)(h)

Te Tiriti o Waitangi, and ensuring proposals uphold the following principles:

- Tino rangatiratanga
- Equity
- Active protection
- Options
- Partnership.

Te Tiriti o Waitangi implications and equity implications have been assessed in the 'analysing the proposals' section.

Outline the key assumptions underlying your understanding of the problem.

The overarching issues that have prompted this problem are:

- Changing public health context, where the risk from COVID-19 has reduced at the current time (although we need to remain prepared for future variants of concern).
- Bill of Rights Implications, noting that with the changing public health context and the length of time the measures have been in place, proportionality continues to evolve.
- Ongoing review of the COVID-19 Protection Framework has identified that while it was effective in responding to Delta and Omicron initially, going forward we'll need a strategic approach that is more flexible and be better suited to the current context (as outlined in the context section).
- The Epidemic Preparedness (COVID-19) Notice 2022 (the epidemic notice) is due for renewal by 15 September 2022. The epidemic notice enables the creation of orders under the COVID-19 Public Health Response Act 2020 (the COVID-19 Act).

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 Public Health Response Act 2020, and other related requirements, we have identified the following criteria.

Proportionality as required in the COVID-19 Act- the extent that the public health rationale (including protection from severe outcomes and hospitalisations) upholds Bill of Rights Act 1990 (BORA) considerations

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- e.g 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 the 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?

This is focussed on the reviewing the public health responses to COVID-19 that require COVID-19 specific Orders, as listed in the problem statement.

Analysing the proposals

You will find the proposals for different options for each of the measures considered below. This is then supported by analysis, including public health advice and multi-criteria assessment.

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

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

The requirement for air travellers to New Zealand to provide information for contact tracing purposes prior to departure

Options

Option 1: Status-quo	Option 2: Remove the requirement for air travellers to provide information for contact tracing purposes
Retain the current requirement for arrivals to New Zealand to provide contact details and travel history information to assist contact tracing under the COVID-19 Public Health Response (Air Border) Order 2021.	Remove the requirement for arrivals to provide contact details and travel history

Public Health Risk Assessment recommendation

PHRA recommendation	That the requirement to provide contact details and travel history information as a condition of being able to depart for New Zealand is retained.

Multi-criteria assessment

Criteria	Option 1: (Status quo) the requirement for air travellers to New Zealand to provide information for contact tracing purposes prior to departure is retained	Option 2: The requirement to provide contact details and travel history information as a condition of being able to depart for New Zealand is removed, with other information gathering methods put in place that are not mandated under COVID-19 specific legislation.
s9(2)(h) [redacted]	[redacted]	[redacted]

Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	The costs associated with gathering the information are likely to be the only costs associated with this measure.	+ Reduced government expenditure on this measure.
Equity- Evidence of the impacts of the measures for at risk populations	This has the potential to support a more effective response to new variants of concern, and with that provide greater protection to at risk communities.	- Without this measure, potential delays and limitations in providing timely contact tracing could slow down a response to a potential variant of concern.
Compliance- expected public compliance with measures	N/A Under this proposal, compliance is not an applicable criteria as it is has been a requirement of entry and option 2 is a removal of the requirement.	
Overall	On balance, and taking a precautionary approach, retaining this measure given the limited imposition that comes with it has the potential to support a more effective response to future variants of concern.	In the event of a future variant of concern, the potential implications for contact tracing prevent this from being the preferred approach.

2.The post-arrival testing requirement for arrivals to New Zealand

Options

Option 1	Option 2
Maintain COVID-19 post-arrival testing requirement for all air and maritime arrivals to New Zealand (including for air crew), noting the public health rationale is now lesser than before. Currently arrivals are required to take a Rapid Antigen Test on day 0/1 and day 5/6, to identify new cases and support surveillance for new variants of concern. When arrivals have a positive Rapid	Amend the COVID-19 Public Health Response (Air Border) Order 2021 and COVID-19 Public Health Response (Maritime Border) Order 2021 to remove the post-arrival testing requirement and replace it with targeted surveillance and information to support effective non-mandatory post-arrival testing

Antigen Test, they are required to take a PCR test to support Whole-Genome Sequencing.	

Public Health Risk Assessment recommendation

PHRA recommendation	Mandatory post-arrival testing at the New Zealand air and maritime border should be removed and replaced with targeted surveillance and information provision measures for travellers, as it is no longer proportionate, is not currently enforced, and cannot be done quickly enough to prevent new variants entering New Zealand.

Multi-criteria Assessment

	Option 1: Maintain COVID-19 post-arrival testing requirement for all air and maritime arrivals to New Zealand noting the public health rationale is now lesser than before.	**Option 2: Amend the COVID-19 Public Health Response (Air Border) Order 2021 and COVID-19 Public Health Response (Maritime Border) Order 2021 to remove the post-arrival testing requirement and replace it with targeted surveillance and information to support effective non-mandatory post-arrival testing**
s9(2)(h) [redacted]	[redacted]	[redacted]

		Delays in WGS for border arrivals (in a context of increasing traveller numbers) mean that new Variants of Concern are likely to be identified in the community first.
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	Post-arrival testing is costly and does not have a significant benefit compared to other surveillance measures in place.	+ Reduces expenditure on a public health measure with limited benefit.
Equity- Evidence of the impacts of the measures for at risk populations	Limited effectiveness, although substantially not more effective than maintaining other surveillance methods in protecting at risk populations.	Ongoing effective surveillance methods would still be in place, and targeted recommended testing for symptomatic cases would remain in place.
Compliance- expected public compliance with measures	Compliance has remained high, however this may wane as other countries move away from this approach and the perception of the public health benefit changes.	+ Compliance for the less intensive regime would be supported by proactive support and clear messaging. Furthermore, by remaining proportionate to public health benefit it will be easier to retain the social license for these measures.
Overall	Given the limited effectiveness of this measure to quickly identify, test and isolate this person who has arrived from a given country, it is not considered proportionate to maintain post-arrival testing.	Given the limited benefit of maintaining post-arrival testing requirements, recommended border testing and the use of other surveillance approaches that reduce the burden on individuals is the preferred option.

The COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand (including for air crew)

Option 1	Option 2
Maintain the COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand (including for air crew), noting the public health rationale is lesser than before. Currently new arrivals (who are not New Zealand citizens, residents or Australian citizens visiting New Zealand) are subject to requirements to be vaccinated with an approved vaccination.	Remove the vaccination requirement for arrivals from the COVID-19 Public Health Response (Air Border) Order 2021 and COVID-19 Public Health Response (Maritime Border) Order 2021

Public Health Risk Assessment process

PHRA recommendation	That vaccination requirements at the air and maritime border be removed as it is no longer justifiable. With Omicron, and the recognition that available vaccines are far less effective in reducing transmission, the current rationale is more about reducing the risk of severe illness, and the potential impact on the health system. Air carriers and maritime vessels can still require evidence of vaccination as a requirement of carriage if they so choose.

Multi-Criteria analysis

Criteria	Option 1 (Status quo): Retain COVID-19 vaccination requirement for all air and maritime arrivals to New Zealand (including for air crew), noting the public health rationale is lesser than this has been.	Option 2: Remove the vaccination requirement for arrivals from the COVID-19 Public Health Response (Air Border) Order 2021 and COVID-19 Public Health Response (Maritime Border) Order 2021
s9(2)(h) [redacted]	[redacted]	[redacted]

s9(2)(h) [redacted]		[redacted] if the requirement is reduced.
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	Likely to have a negative economic impact, unless the increase in travellers place an excessive burden on the health system.	+ Likely to have a positive economic impact with improved ease of travel for unvaccinated travellers
Equity- Evidence of the impacts of the measures for at risk populations	To date this has provided increased protection from severe illness and prevented hospitalisations however this risk is decreasing.	- This may lead to a small increase in cases.
Compliance- expected public compliance with measures	N/A- This is currently a requirement for entry and the other option is to remove the requirement.	
Overall	Given this measure serves a limited public health benefit, retaining it is unlikely to be tenable. Further consideration needs to be given to additional protections for at risk communities.	On balance, given the limited rationale for maintaining the measure, and that the vaccination requirement is no longer considered proportionate, this is the preferred option.

The requirement for travellers to New Zealand not to exhibit symptoms or be under a public health direction

Options

Option 1	Option 2
Maintain requirement in the COVID-19 Public Health Response (Air Border) Order 2021 for arrivals to New Zealand to not exhibit COVID-19 symptoms on arrival or to be under a public health direction from another country.	Remove the requirement for arrivals to New Zealand to not exhibit COVID-19 symptoms on arrival or be under a public health direction from another country.

Public Health Risk Assessment

ODPH Recommendation *this has been considered by the Office of the Director of Public Health separately to the Public Health Risk Assessment	The Office of the Director of Public Health (ODPH) recommends that the requirement for travellers to New Zealand to not exhibit symptoms of COVID-19 and not be subject to a public health direction in another country is now removed. Given the current level of COVID-19 cases and hospitalisations in New Zealand, the decreasing strain on the health system, and that people may be pre-symptomatic or asymptomatic with COVID-19, there is no strong rationale for maintaining this requirement. We can instead revert to recommending that people who are unwell who don't travel, and the previous (pre-COVID-19) processes for dealing with passengers who display symptoms of being unwell[1].

Multi-criteria analysis

[1] This could involve airlines using their fitness to travel rules, and provisions within the Health Act 1956 which may include mandatory contact tracing, various types of mandatory directions and court orders, urgent public health orders to tain the person for 72 hours, and prosecution as a last resort. This is outlined here: https://www.health.govt.nz/system/files/documents/publications/guidance-infectious-disease-management-under-health-act-1956-feb17-v4.docx

Criteria	Option 1: (Status quo) Maintain the requirement for arrivals to New Zealand to not exhibit COVID-19 symptoms on arrival or not be under a public health direction from another country	Option 2: Remove the requirement for arrivals to New Zealand to not exhibit COVID-19 symptoms on arrival or be under a public health direction from another country
s9(2)(h) [redacted]	[redacted]	[redacted]
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	Minimal social or economic benefit of this measure at this time	+/- Minimal social or economic benefit of removing this measure
Equity- Evidence of the impacts of the measures for at risk populations	No change	- Given the small increase in public health risk, removing the measure is likely to have a small increase in health risk for at risk populations. However, the use of previous (pre-COVID-19) processes for dealing with passengers who display symptoms of being unwell will reduce this risk.

Compliance- expected public compliance with measures	In our current high trust-model, we would expect all people to follow any public health direction they may be under whether this is from another country or New Zealand. As there is no systematic way of verifying if a traveller is under a public health direction, this requirement is likely to be of little benefit. Airlines are also required to check the passenger compliance with all COVID-19 provisions, which may be undertaken at check-in or boarding, but is not systematic.	
Overall	Given the limited public health or compliance rationale, maintaining this requirement is unlikely to be proportionate.	+ Given the current level of COVID-19 cases and hospitalisations in New Zealand, the decreasing strain on the health system, and that people may be pre-symptomatic or asymptomatic with COVID-19, there is no strong rationale for maintaining this requirement. Furthermore, compliance challenges make strengthen the rationale for removing the measure.

. The requirement for household contacts to quarantine for 7 days

Options

Status quo	Option 1	Option 2
The requirement for household contacts to quarantine at home for 7 days is retained, to minimise the risk of household contacts who have not yet tested positive to spread COVID-19.	This requirement for self-isolation is removed and replaced with guidance that household contacts test daily for 5 days. Daily testing should commence from when the first case in the household tests positive (the public health recommendation).	The current requirement for mandatory self-isolation is removed and a mandatory requirement for testing on day 3 and day 5 replaces the current requirement for mandatory testing on day 3 and day 7

Public Health Risk Assessment summary

PHRA Recommendation	The public health advice is that the requirement for household contacts to quarantine for 7 day should be replaced with guidance to test daily for 5 days.

	On the basis of proportionality, the current outbreak context, and overseas experience, daily testing of household contacts provides a sufficient risk mitigation if quarantine is removed. Daily testing rather than a 'test-to-leave' approach was favoured to support efforts to identify cases early. While removing household quarantine would increase cases, on balance it was marginal when considering the large impact quarantine itself was having on larger households especially, and wider society. Therefore, noting lead times and the outcome of consultation, we consider that now is the right time to remove the requirement. It is acknowledged that the modelled increases in case numbers and hospitalisations are expected to have a disproportionate impact on Māori, Pacific and other vulnerable communities who experience a higher burden of severe disease and may be more likely to work in jobs where they cannot work from home when unwell.

Multi-criteria analysis

Criteria	Status Quo – Self-isolation mandate (case & contacts)	Option 1: Guidance recommending daily testing for five days	Option 2: Mandatory testing on day 3 and day 5
s9(2)(h)			

Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	Status quo likely results in more total isolation days across the population than options that do not require household contacts to quarantine International evidence indicates that regulated mandatory requirements enable those who don't have access to sick pay or leave to be able to do so with their employers, unlike guidance. The economic impact of CPF Orange was estimated at 1%-2% of GDP in aggregate, $105m per week, with the most significant impact being from self-isolation	+/- The likely overall impact is uncertain. Moving to voluntary 5-day testing would be likely to result in an increase in the number of cases, which would have negative economic and social impacts. However, reducing the level of self-isolation required from 7 to 5 days would have offsetting positive economic and social impacts as household contacts who do not contract the virus would be able to return to work or other activities earlier. Modelling earlier in 2022 indicated that 78% of household contacts became cases. Later modelling has used a figure of 60%, based on the likelihood that the rate of infection has dropped as Omicron moved into households with fewer people and relatively more living space.	+/- See comments for Option 1.
Equity- Evidence of the impacts of the measures for at risk populations	Compared to other options, this is likely to be the most effective in reducing the public health risk.	- The modelled increases in case numbers and hospitalisations are expected to have a disproportionate impact on Māori, Pacific and other vulnerable communities who experience a higher burden of severe disease and may be more likely to work in jobs where they cannot work from home when unwell.	- Older people, Māori, Pacific Peoples, and disability communities are likely to be disproportionately impacted by any decision to remove 7-day case isolation

Compliance- expected public compliance with measures	Compliance with the measure currently is varying, based on the outcomes of waste water surveillance and survey evidence. An online survey in June found that 88% of respondents said they would follow self-isolation rules. It is likely that compliance would remain higher than options 1 and 2 Because some people are more likely to comply with a legally mandated requirement than to a voluntary requirement.	+/- Level of compliance is difficult to ascertain. Compliance would be supported by communications, and the provision of free Rapid Antigen Tests. The shift to a voluntary approach may be read as a signal that compliance is a lower government priority, leading to lower compliance than the status quo. On the other hand, the relatively low burden of compliance involved (taking a daily RAT) may mean that compliance remains at or near current levels	- Level of compliance is difficult to ascertain. Compliance would be supported by communications, and the provision of free Rapid Antigen Tests. The shift away from mandatory self-isolation may be read as a signal that compliance is a lower government priority, leading to lower compliance than the status quo. On the other hand, the relatively low burden of compliance involved (two mandatory RATs) may mean that compliance remains at or near current levels. This option presents issues of enforcement which may lead to lower compliance and effectiveness.
Overall		+ Preferred over the status quo and option 2, due to it being proportionate and still providing an effective public health response.	- Preferred over the status quo, due to it Representing a shift away from a mandatory approach to a voluntary approach supported by guidance being proportionate and still providing an effective public health response. Ranked after option 1 due to compliance issues discussed above.

The 7-day case isolation requirement

Counter-factual and proposal

Option 1	Option 2
Status quo: the 7-day case isolation requirement remains in place to support the ongoing effective isolation of cases, to prevent spreading COVID-19 outside the household.	Remove mandatory 7-day self-isolation for cases and replace with guidance

Public Health Risk Assessment

PHRA recommendation	Maintain the current 7-day COVID-19 case isolation requirement, at this time. Isolation of infectious cases to reduce community transmission remains an important way to suppress transmission of COVID-19 and subsequently higher numbers of cases, hospitalisations, and deaths. Removing 7-day case isolation while there is still a high degree of COVID-19 circulating around society risks prolonging the current COVID-19 outbreak, so that it is longer or more severe than necessary in its impact. There remains widespread support for retaining case isolation requirements from Medical Officers of Health and public health units throughout the country.

Multi-criteria assessment

Criteria	Option 1: (Status quo) retain 7-day self-isolation requirements for cases	Option 2: removing mandatory self-isolation for cases
s9(2)(h) [redacted]	[redacted]	[redacted]

s9(2)(h) [redacted]	[redacted]	[redacted]
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- The ongoing use of self-isolation is likely to maintain current levels of self-isolation days, however if this is removed it would need to be traded off against the negative health impacts. The economic impact of CPF Orange was estimated at 1%-2% of GDP in aggregate, $105m per week, with the most significant impact being from self-isolation. There are wider impacts that are felt across education, health, and other critical services, and on wider society. It's important to note that these impacts will decrease as overall case numbers decrease.	
Equity- Evidence of the impacts of the measures for at risk populations	Maintaining these requirements reduces potential cases, hospitalisations and deaths, particularly for communities who are at greater risk.	- Certain communities are likely to be disproportionately impacted by any decision to remove 7-day case isolation. In particular, before removing this measure it will be important to engage with these communities, including representatives of older people, Māori, Pacific Peoples, and disability communities.
Compliance- expected public compliance with measures	While it remains a requirement, compliance is likely to be higher.	- Moving away from a compulsory requirement is likely to decrease the level of compliance.

Overall	Given the potential public health impacts, this remains effective, justifiable and proportionate at this time. It will be critical that this remains under constant review.	- Moving away from this approach at this time is likely to increase the public health risk and resulting impacts.

The COVID-19 Public Health Response (Vaccinations) Order 2021 which includes the vaccination mandates for health and disability sector workers

Options

Option 1	Option 2
The COVID-19 Public Health Response (Vaccinations) Order 2021 which includes the vaccination mandates for specified health and disability sector workers to be vaccinated to continue to work in their role.	Revoke the vaccination mandate for health and disability sector workers

Public Health Risk Assessment

PHRA recommendation	Revoke the Vaccinations Order and remaining vaccination mandates for health and disability sector workers as soon as possible. The public health rationale for this measure no longer exists. This reflects the very high vaccination rate among the affected workforce and the overall reduced efficacy of vaccination against COVID-19 transmission. Focus has also now shifted from population level measures (e.g. mandate) to more individual measures (e.g. that it is more important that patients are vaccinated in the first place).

Multi-criteria analysis

Criteria	Option 1: (Status quo) the COVID-19 Public Health Response (Vaccinations) Order 2021 which includes the vaccination mandates for health and disability sector workers remains in place	Option 2: Revoke the vaccination mandate for health and disability sector workers
s9(2)(h)		
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	The ongoing mandate may be preventing some people from entering the workforce.	+ This may be an opportunity for some unvaccinated people to re-join the health and aged care workforce, where there are not ongoing vaccination requirements through the Health and Safety at Work 2015 requirements.
Equity- Evidence of the impacts of the measures for at risk populations	given the limited ongoing public health benefit, it is unlikely to increase the public health risk for at risk populations	+/- given the limited ongoing public health benefit of the mandate, it is unlikely to increase the public health risk for at risk populations
Compliance- expected public compliance with measures	N/A	
Overall		+

	Given that this measure currently is not supported by an ongoing public health rationale, retaining the mandate is no longer likely to be proportionate.	The proposed removal of this measure would be proportionate and not increase the public health risk.

6. Masking settings.

Options

Option 1	Option 2 (PHRA Proposal)	Option 3
Maintaining the requirement for mask use in many indoor settings and on public transport (i.e. CPF Orange settings) to reduce transmission.	Retain mask requirements on public transport and in healthcare settings (including aged residential care)	Mask guidance (no mandates)

Public Health Risk Assessment

PHRA recommendation	Retain mask requirements on public transport and in healthcare settings (including aged residential care) but remove mandates in other settings. Develop guidance to encourage ongoing use in other essential settings (e.g. supermarkets) like the approach with schools. This was considered an appropriate step-down option as we come out of winter and are reducing other requirements (e.g. household quarantine). Other essential services (e.g. supermarkets) have shown to be lower risk settings. While there was not support for removing all current mask mandates, there was support for considering options to reduce requirements where this was supported from a public health perspective.

Multi-criteria analysis

Criteria	Option 1: Maintain the status quo for	Option 1 – Ongoing mask requirements in 'public transport' and 'healthcare settings'	Option 2 – Mask mandates are removed and replace with guidance

	Masks		
s9(2)(h) [redacted]	[redacted]	[redacted]	[redacted]
Economic and social impact- evidence of the effects of the measures on the economy and society more broadly	+/- Aggregate economic impact of stepping down mask mandates relative to the status quo is relatively small, particularly as guidance will be communicated and some level of compliance is retained		

Equity- Evidence of the impacts of the measures for at risk populations	Current mask use provides effective protection for Māori, Pacific Peoples, disabled people and people living in areas of high deprivation	+/- Māori, Pacific Peoples, disabled people, and people living in areas of high deprivation are likely to be disproportionately affected if mask mandates were stepped down.	- Māori, Pacific People, Disabled people, and people living in areas of high deprivation are likely to be disproportionately affected if mask mandates were entirely removed and replaced with guidance.
Compliance- expected public compliance with measures	o	+ Survey respondents indicated a willingness to mask but social norms to masking were variable with signs of waning adherence in the status quo. Measures are most complied with and effective when people understand their rationale, and retaining mask requirements in essential close contact is commensurate with the reducing COVID-19 risk profile	- The evidence suggests adherence is higher when there is a mandate relative to guidance. Ongoing mask use is a highly useful "COVID legacy" but will require time to become a behavioural norm
Overall	o	+	-

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.

The preferred option to remove several mandated public health measures at the border and reducing measures domestically may impact these priority populations. The proposal to reduce mandatory measures relies on established baseline measures being in place, which means maintain high vaccination rates, good public access to masks and rapid antigen tests (RATs) and improving access to antivirals for those most vulnerable to getting very unwell from COVID-19.

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. Removing measures such as border measures that are not expected to affect the burden on the health system overall may result in the burden being transferred to and disproportionately experienced by priority populations.

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. The new strategy 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). It is important that consultation on the proposed changes is carried out to identify the potential impacts on these groups and mitigations. Given that, any stepping down of mandatory measures will need to be accompanied by close monitoring of how the changes impact vulnerable populations.

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. As measures are stepped down, the Manatū Hauora Māori Protection Plan is critical. The plan, due to expire in December 2022, focuses on:

- protecting whānau, hapū, iwi and hapori Māori from the virus by increasing vaccination coverage
- building the resilience of Māori health and disability service providers and Māori whānau, hapū, iwi and hapori Māori to respond to the new environment of the Delta variant, the COVID-19 Protection Framework and the long tail of the impact of COVID-19 on the health and wellbeing of Māori.

For Māori, 86.6 percent of people are at least partially vaccinated and 56.1 percent of Māori 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.

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 Pacific Peoples are the demographic most hospitalised for COVID-19 and their COVID-19 mortality rate is four times greater than European or other ethnicities. This is further compounded by the severity of the 2022 flu season.

91.4 percent of Pacific peoples are at least partially vaccinated (compared to 91.5 percent across all ethnicities) and 60.8 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 removing mandatory measures.

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. Removing mask requirements and self-isolation changes will have an increased impact amongst this group.

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. The continuation of measures, particularly face masks when accessing essential services, creates reassurance. Changes to these requirements in the future are likely to cause greater anxiety and risk for disabled people, particularly those with underlying co-morbidities.

The proposal to remove the requirement that household contacts quarantine and instead complete daily RATs for 5 days may present an equity risk for disabled people and tāngata whaikaha Māori, who have difficulty in accessing testing resources. Whaikaha advise that extra support and strong communication is needed to ensure disabled people can meet this new requirement, including continuing to explore alternative testing modalities outside of RATs and PCR tests.

The removal of vaccination mandates, and reduced self-isolation requirements for household contacts will likely positively impact workforce capacity and therefore

continuity of services. However, engagement with the disability sector raised the importance of ensuring disabled people and tāngata whaikaha Māori have choice and control over the vaccination status of their support workers.

Without data disaggregated by disability, determining impacts of variants of concern or public health measures on disabled people and tāngata whaikaha Māori would be difficult.

Equity analysis for other groups

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.

Removing the requirement for household contacts to self-isolate will reduce disruption in the education sector for children, young people, and education workers, and enable tertiary education providers to continue delivering services which have been challenged by staff shortages. More learners will be able to access in-person learning.

Transitioning from mandatory isolation of household contacts to testing requirements or guidance will be more challenging for prisons to implement, as prison units are treated as households for the purpose of these requirements.

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 found that the Government's rapid transition into the CPF breached Te Tiriti principles of active protection, equity, tino rangatiratanga, partnership and options.

Given that the PHRA (supported by further analysis) recommends stepping down several mandated measures such as, the Māori Protection Plan's two key drivers are critical. Related 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[2], and COVID-19 and flu vaccinations.

In DPMC's discussions with NICF members about stepping down mandatory measures, they were concerned about tino rangatiratanga, particularly over marae – i.e., marae should be empowered to manage the welfare of their people rather than having requirements externally mandated. This would support the removal of broad-based population requirements such as the CPF. The suggestion was to replace it with accessible guidance on best practice and continued communications to address the complacency and misinformation some NICF members are observing. NICF members have also observed the

[2] In the week ending 24 July 2022, nine percent of antiviral courses went to Māori while they accounted for 10 percent of reported COVID-19 cases.

hardship that requiring household contacts to isolate placed on many whānau, and that there will be some support for the removal of this requirement.

Further work will be needed to develop public health measures that will better 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. 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?

Based on an overall assessment, we propose to:

a. remove vaccination requirements, post-arrival testing requirements (replaced with recommendations to test), and requirements not to exhibit symptoms for arrivals;
b. retain requirements for air travellers to provide information for contact tracing purpose prior to departure;
c. remove all remaining vaccination mandates;
d. retain mandatory self-isolation of cases
e. retaining masks requirements on public transport and healthcare settings (including aged residential care)
f. replace self-isolation requirements for household contacts with guidance to test daily for five days;

For self-isolation for household contacts, two options are provided:

- Option 1: guidance only to test daily for 5 days for household contacts (our preferred option)

  or

- Option 2: mandatory day 3 and day 5 testing for household contacts.

The rationale for maintaining option 1 is proportionate and still providing an effective public health response.

Section 3: Delivering an option

How will the new arrangements be implemented?

The proposals in this paper require amendments to Orders made under the Act. Moving to the new strategy and adjusting mandated public health measures requires:

- Revoking the COVID-19 Protection Framework Order;
- Amending the Air Border Order;
- Amending or revoking the Maritime Border Order[3];
- Revoking the Vaccinations Order;
- Amending the Self-Isolation and Permitted Work Order; and

[3] While the Air Border Order will continue to be required to provide for the preferred approach to retaining a requirement to provide contact tracing information, the Maritime Border Order will have no active public health requirements if the proposals in this RIA are accepted. Pending further considering, it's possible that giving affect to the proposals in this analysis will result in revocation of the Maritime Border Order.

- Making a new mask order.

There are no changes proposed to the to the remaining Orders under the Act, being the COVID-19 Public Health Response (Isolation and Quarantine) Order 2020; and the COVID-19 Public Health Response (Point-of-care Tests) Order 2021.

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

For the most part, where further measures are required to support ongoing adherence to public health advice or where additional surveillance is required, this is already in place. Work is progressing on the development of communications for new arrivals, and the additional surveillance required is already in place.

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

The epidemic notice can only be renewed if the Prime Minister is satisfied that the effects of an outbreak of COVID-19 are likely to continue to significantly disrupt essential governmental and business activity in New Zealand (or the parts of New Zealand concerned) significantly. It has been renewed by the Prime Minister every three months since the epidemic was first declared with the agreement of the Minister of Health and the Minister for COVID-19 Response and on recommendation of the Director-General of Health.

COVID-19 orders may only be made while the epidemic notice is in force, while a state of emergency or transition period in respect of COVID-19 under the Civil Defence Emergency Management Act 2002 is in force, or if the Prime Minister has authorised the use of COVID-19 orders, either generally or specifically.

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

The public health measures will remain under regular monitoring and review, with a proposal to review continued mandatory requirements through the Public Health Risk Assessment process s9(2)(f)(iv) [redacted]