

# Briefing

## Ministry of Health Response Shifts to Respond to the Risks of the Delta Variant

**Date due to MO:** Friday 6 August 2021      **Action required by:** <N/A>

---

**Security level:** IN CONFIDENCE      **Health Report number:** HR20211793

---

**To:** Hon Chris Hipkins, Minister for COVID-19 Response

---

### Contact for telephone discussion

Name	Position	Telephone
<b>Bridget White</b>	Deputy Chief Executive, COVID-19 Response	s 9(2)(a)
<b>Maree Roberts</b>	Deputy Director General, System Strategy and Policy	s 9(2)(a)

### Minister's office to complete:

- |   |                                    |  |
|---|------------------------------------|--|
| <input type="checkbox"/> Approved             | <input type="checkbox"/> Decline   | <input type="checkbox"/> Noted               |
| <input type="checkbox"/> Needs change         | <input type="checkbox"/> Seen      | <input type="checkbox"/> Overtaken by events |
| <input type="checkbox"/> See Minister's Notes | <input type="checkbox"/> Withdrawn |  |

Comment:

# Ministry of Health Response Shifts to Respond to the Risks of Delta Variant

---

**Security level:** IN CONFIDENCE      **Date:** 6 August 2021

---

**To:** Hon Chris Hipkins, Minister for COVID-19 Response

---

## Purpose of report

1. This report responds to your request for a briefing on the current position of the Ministry of Health (the Ministry) in light of the emerging Delta variant of COVID-19, and details shifts in operational practice to response to the increased threat. This report discloses all relevant information.

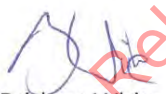
## Summary

2. The emergence of the Delta variant of COVID-19 globally is not an unexpected shift in viral evolution, however, does pose a higher level of risk to New Zealand, illustrated by the outbreaks of this variant in Australia.
3. The currently employed Elimination Strategy remains appropriate in light of the increased risk, however our approach to responding to the increased risk will need to shift.
4. Emerging science around the Delta variant shows that there is a higher viral load earlier on in infection, and it is generally more transmissible than the 'original' virus and other variants of concern.
5. The impact of this is that, in order to maintain elimination, our response will need to be faster, possibly last for longer, employ more stringent public health measures than may have been previously used, and possibly use these more widely, including the use of Alert Level 4 restrictions if necessary.
6. An internal working group at the Ministry has been established to drive a programme of work as part of our continuous review process, reviewing each of the response areas and updating them to ensure they are fit for purpose to respond to the threat posed by the Delta variant. This programme of work is intended to be completed largely by the end of August.
7. This work links to the Reconnecting New Zealand work programme, particularly focusing on the readiness of the health system and wider system readiness for any shift in the border settings.

## Recommendations

We recommend you:

- a) **Note** that the shift in our response strategy in light of the increased risk due to the Delta variant can be summarised as “faster, longer, harder, wider.”
- b) **Note** that the Ministry of Health has undertaken a rapid review of each response area to ensure they are fit-for-purpose in light of the increased threat posed by the Delta variant.
- c) **Note** the outcomes of the rapid review have fed into the continuous improvement cycles the Ministry has operating routinely, with a new ‘Delta’ lens
- c) **Note** this work links to the Reconnecting New Zealand work programme, particularly focusing on the readiness of the health system and wider system readiness for any shift in the border settings. The Ministry will continue to work with DPMC on the wider programme.
- d) **Note** that the Ministry has asked DHBs to review their preparedness plans in light of the Delta variant, and has been actively working with the 12 PHUs over the last 8 weeks to develop and test their enhanced readiness.
- e) **Note** that the Ministry will provide you an update by 21 August 2021, including an update on the continuous improvement work, key messages for public communication of a response that may need to be more aggressive: “faster, longer, harder, wider,” and any updates in global scientific knowledge regarding the behaviour and impact of the Delta variant.



Bridget White  
Deputy-Chief Executive

**COVID-19 Response**

Date: 6/8/21



Hon Chris Hipkins

**Minister for COVID-19 Response**

Date: 12/8/2021

# Ministry of Health Response Shifts to Respond to the Risks of Delta Variant

## Context

1. The emergence of the Delta variant of COVID-19 globally is not an unexpected shift in viral evolution. However recent scientific evidence shows that this variant poses a higher level of risk to New Zealand, as demonstrated by outbreaks of this variant in Australia.
2. Given this higher level of risk, it is prudent that the Ministry re-considers our response frameworks and health system settings.
3. This briefing provides the first update, outlining how the Ministry is revising the COVID-19 public health and health system response in light of the risks posed by the Delta variant.

## What we know about the Delta variant to date

4. The Delta variant is swiftly becoming the dominant global variant of COVID-19.<sup>1</sup> There may be an increased risk of people who have previously been infected with COVID-19 being re-infected by the Delta variant.<sup>2</sup> Emerging evidence suggests that Delta variant infections have worse clinical outcomes compared to previous variants of COVID-19, and wild type COVID-19.<sup>3</sup> Recent global evidence suggests that the Delta variant has 1000 times the viral load of previously circulating variants. The incubation period (time from exposure to first positive PCR test) seems to be shorter with the Delta variant.<sup>4</sup>
5. Based on current evidence, the Pfizer vaccine seems to still be effective against the Delta variant with the vaccine effectiveness after two doses at 88%.<sup>5</sup> However, we know that vaccination may not prevent infection or reduce transmission as effectively, as it did with earlier variants.

## What this will mean for the Ministry's response to cases

6. Given the current scientific knowledge about the personal and community impact of the Delta variant, our approach to response needs to assume that every case coming into

---

<sup>1</sup> All sequenced cases in New Zealand from 19 July 2021 to 26 July 2021 reported by ESR were the Delta variant, an increase of 48 Delta sequences from the previous VOC update.

<sup>2</sup> Preliminary analysis of national surveillance data in the UK has found an increased risk of re-infection with Delta compared to Alpha.

<sup>3</sup> Hospitalisation and deaths analyses now indicate that the severity of COVID-19 caused by Delta is at least as great as that of Alpha (low confidence).

<sup>4</sup> Median incubation period is ~4 days for Delta, compared to ~6 days for previously circulating variants.

<sup>5</sup> An article previously reported on in a VOC update as a pre-print has now been published in the New England Journal of Medicine. In a test-negative case-control analysis by Lopez Bernal et al (2021), the estimated vaccine effectiveness against symptomatic disease caused by the Delta variant was 35.6% (95% CI: 22.7-46.4%) after one dose of the Pfizer vaccine and 88.0% (95% CI: 85.3-90.1%) after two doses.

New Zealand or detected in the community is a Delta variant infection. This is supported by the last two weeks of whole genome sequencing, where every successful sequence was a Delta variant. While we have the capacity to do very quick genome sequencing (as fast as 7 hours), the response needs to be swift and assume the worst-case scenario right from the acutely positive test result.

7. The science shows us that Delta has a higher viral load overall, and this occurs earlier in the incubation period compared to the original virus. This means that cases are likely to be highly infectious, and possibly highly infectious **before** they are tested and isolated. This has been seen in the recent outbreak of Delta in New South Wales, with a large number of cases infectious while in the community. The risk of onward transmission is high, particularly to close household contacts. Early detection of cases, swift contact tracing, and containment will be key to a successful response.
8. It is important to note that with the shorter incubation period and high likelihood of transmission, contacts are likely to become acutely infectious quicker, which increases the likelihood of multiple cases at once, possibly with significant travel history given the lack of restrictions on regional travel in Alert Level 1.
9. Overall, it is our position that any future national COVID-19 response needs to assume the worst-case scenario, assume any cases are the Delta variant, and enable a response that is faster, more stringent, and wider reaching than previous responses, and which may need to be sustained for longer.

### **A 'Delta lens' has been applied as part of continuous improvement to revise and refresh the Ministry's frameworks and health system settings**

10. The Ministry has established an internal working group to drive a rapid review and programme of work as part of our continuous improvement that will review each of the response areas and update them if necessary, to ensure they are fit for purpose to respond to the increased threat posed by the Delta variant.
11. The rapid review and continuous improvement response work to assess our readiness and response capacity and capability, as well as our currently existing standard operating procedures (SOPs) to ensure they are updated to reflect the increased risk.
12. Broadly the main areas of focus for the working group are as follows;
  - a. Assessing and revising the settings within our current Alert Levels and how we would use them in the event of community transmission in New Zealand,
  - b. Assessing our case management and contact tracing SOPs and systems to ensure they reflect the emerging science, including isolation protocols,
  - c. Assessing the response capacity and capability to support a sustained 'worst-case scenario' response including an end to end review of the testing system,
  - d. Assessing the impact of community cases on the vaccination program and vice versa, including workforce.
13. This programme of work is intended to be completed largely by the end of August, with larger pieces of work due for completion in mid-September. The work has been prioritised according to risk, with many pieces of work already completed or well underway.

## Document 1

14. There is also a similar process being undertaken by the DPMC COVID-19 Group testing and preparing the wider All of Government system for readiness in light of the Delta variant, with a report back to COVID-19 Chairs Board on 17 August 2021, which the Ministry are supporting.
15. We will inform you of any system-level changes that may need Cabinet approval and/or agreement. For example, updated public health orders, changes to the Alert Level system or policy options for consideration in addressing workforce challenges.

### **Ensuring equity in light of the Delta variant**

16. Protecting the health and wellbeing of Māori, Pasifika and other priority populations is integral to the health system response to COVID-19.
17. Achieving equity continues to be a core Government and Ministry priority, as we know higher-risk populations face adverse health outcomes. This was seen with the 2020 August Auckland and Waikato Outbreak which disproportionately affected Māori and Pasifika communities.
18. Whilst we have internal and external expertise readily available to support the Ministry's response and to ensure equity is built into all our functions, actions and pathways, we are cognisant that the overall health response to COVID-19, and particularly the use of the Alert Level framework, have significant equity implications that must be taken into consideration.
19. The Ministry is aware that the Alert Level framework, as it currently stands, makes several assumptions that do not necessarily hold for Māori and other at-risk populations. In updating the Ministry's use of such frameworks, we will continue to ensure equity is a lens that is embedded throughout.
20. The Ministry will continue to ensure cultural understanding, practices and identities are supported across the updated response frameworks in light of the Delta variant, as well as across actions that impact the wider health system.

### **Next steps**

21. The Ministry will continue to work with DPMC and the wider system on readiness and communications.
22. The Ministry will work through the outcomes of the rapid review outlined and will provide you an update by 21 August 2021, including an update on progress of the continuous improvement work, key messages for public communication of "faster, longer, harder, wider," and any updates in global scientific knowledge regarding the behaviour and impact of the Delta variant.

**ENDS.**

# Briefing

## COVID-19: Outbreak phases and management approach

<b>Date due to MO:</b>	16 August 2021	<b>Action required by:</b>	N/A
<b>Security level:</b>	IN CONFIDENCE	<b>Health Report number:</b>	HR 20211740
<b>To:</b>	Hon Chris Hipkins, Minister for COVID-19 Response		
<b>Copy to:</b>	Hon Dr Ayesha Verrall, Associate Minister of Health		

### Contact for telephone discussion

Name	Position	Telephone
<b>Bridget White</b>	Deputy Chief Executive, COVID-19 Health System Response	s 9(2)(a)
<b>Chrystal O'Connor</b>	Acting Group Manager, COVID-19 Contact Tracing	s 9(2)(a)

### Minister's office to complete:

- |   |                                    |  |
|---|------------------------------------|--|
| <input type="checkbox"/> Approved             | <input type="checkbox"/> Decline   | <input type="checkbox"/> Noted               |
| <input type="checkbox"/> Needs change         | <input type="checkbox"/> Seen      | <input type="checkbox"/> Overtaken by events |
| <input type="checkbox"/> See Minister's Notes | <input type="checkbox"/> Withdrawn |  |

Comment:

# COVID-19: Outbreak phases and management approach

---

**Security level:** IN CONFIDENCE                      **Date:** 16 August 2021

---

**To:** Hon Chris Hipkins, Minister for COVID-19 Response

---

**Copy to:** Hon Dr Ayesha Verrall, Associate Minister of Health

---

## Purpose of report

1. The purpose of this report is to respond to your request for further information on how the contact tracing system would operate across different phases of a COVID-19 outbreak.
2. This report discloses all relevant information and implications.

## Summary

3. The contact tracing system has proven effective in managing a range of community outbreaks and, more recently, supporting Quarantine Free Travel (QFT). Each event has presented new opportunities to strengthen the response and enabled the system to evolve.
4. As observed internationally, the risk posed to New Zealand is increasing, particularly given the rise of variants of concern including the Delta variant. It is vital that as the threat of outbreaks become more serious and widespread, the response focus and management strategies adapt. As detailed in Appendix One, the response approach can be characterised into three phases:
  - Phase One – *going hard, going early*; utilising all tools and resources available to prevent an outbreak taking hold.
  - Phase Two – *driving down the numbers*; adjusting the use of available management strategies to focus on the regions and clusters that present the greatest potential to reduce the spread of the disease through contact tracing and other public health interventions.
  - Phase Three – *regain control*; applying population-based management strategies to reduce and minimise social interactions thereby limiting the spread of disease.
5. At each phase, there are different management strategies that can be applied to manage the risk of transmission.
6. The ready contact tracing capacity across Public Health Units and the National Investigation and Tracing Centre is scaled to manage a Phase two outbreak. These resources are also readily available to manage a Phase one outbreak.



## Document 2

7. The surge contact tracing capacity is activated as the response moves towards Phase three, where additional capacity is required to manage increasing case and contact numbers.

### Recommendations

We recommend you:

- a) **Note** that the Phase one and two ready capacity is up to 150 new cases per day and 5,400 new contacts per day and the Phase three surge capacity is up to a total of 1,000 new cases per day and 6,000 contacts per day. **Yes/No**
- b) **Agree** to the contact tracing capacity expectations to respond to initial, significant and major COVID-19 outbreaks in New Zealand. **Yes/No**



Bridget White  
Deputy Chief Executive  
**COVID-19 Health System Response**  
Date:

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

Released under the Official Information Act 1982

# COVID-19: Outbreak phases and management approach

## Context

8. This paper follows on from advice provided to you on 1 July 2020<sup>1</sup> regarding contact tracing system capacity (HR20211272 refers).
9. As has become clear through New Zealand's management of a range of outbreaks of COVID-19, and through observing international responses to major outbreaks, outbreaks are dynamic and the approach to managing these must also be dynamic.
10. The phased approach, as depicted in Appendix One, outlines the expected situation at each phase including the number of case and clusters as well as the ratio of contacts per case, and whether the source of these new cases is known. These are key indicators that determine the phases of a growing outbreak.
11. There are a number of different outbreak management strategies which can be utilised including:
  - Source investigation – undertaken intensively during phase one
  - Whole genome sequencing – utilised at Phase one to support source investigation
  - Contact tracing – most extensive at phase one, and then becomes more targeted based on the clusters/areas that present the greatest public health risk.
  - Public health measures including regional and national changes to Alert levels.
  - Testing – both according to the case definition as well as surveillance.
12. The impact of these outbreak management strategies varies across the different phases of an outbreak. Appendix One details how the system will respond to an outbreak including the degree to which the management strategies that are applied at each phase.
13. The national contact tracing system capacity available to be drawn on at each phase is also included in Appendix One. The relevant management strategies that are utilised at each phase, including public health measures including changes to Alert Levels, testing, contact tracing, form the basis of this capacity planning.
14. A key consideration in informing our response framework is the observation of how variants of concern are being managed internationally.

## What defines each of the outbreak phases?

15. The outbreak phases are primarily determined by the extent of uncontrolled transmission occurring in the community.

### Phase one: Community cluster(s)

16. The scope of this phase is comparable to the range of outbreaks managed in New Zealand between May 2020 and July 2021. Generally, these were localised to specific populations groups and/or areas and controlled within four generations of transmission.
17. This early phase would be typified by low case numbers, very few clusters, very few if any cases with unknown sources of infection and high contact to case ratios. The focus of the response is intensive source attribution work, coupled with extensive contact identification and control.
18. In this phase, the risk tolerance is very low and requires 'pulling out all stops' approach to control the outbreak.

### Phase two response: Significant outbreak response

19. The scope of this phase is similar to the New Zealand outbreak between March and April 2020 and categorised by widespread transmission.
20. This phase would be typified by high case numbers, multiple clusters across a range of settings of concern and an increasing number of cases without a known source of infection.
21. The focus shifts from intense source attribution to cluster control, spread prevention with individual cases and contacts. The outbreak is likely to have had at least five generations of transmission within the community.
22. The response approach would shift to a transmission reduction approach that would see a steady reduction of new case numbers using a range of tools including population interventions (e.g. mandated mask-wearing, physical distancing, change in alert levels, limits on gathering size).
23. The contact tracing system would also prioritise its capacity to focus on ensuring individuals are isolating in a timely manner i.e., the mode of communicating with contacts in isolation could change from phone to email follow-up.

### Phase three response: Major outbreak response

24. The scope of this phase would be beyond anything New Zealand has currently experienced and is more akin to the Melbourne outbreak in July 2020 or the July/August 2021 Fiji outbreak.
25. This phase would be typified by very high number of cases and clusters and high numbers of cases with unknown sources of infection.
26. The focus of the response at this level would be on regaining control of the outbreak through population health interventions such as widespread medium to long term lockdowns.

### The application of the outbreak phases

27. The outbreak phases are a tool for distinguishing the different management strategies that may be used in an outbreak. It is anticipated that the transition through the phases is likely to occur quickly depending on the nature of the outbreak, as opposed to a stepwise linear progression.

## Document 2

28. A key assumption to the national outbreak management strategy is that the response phases may be applied differently across the country, based on the extent of community outbreak experienced within each region.

### Capacity at each phase

29. The New Zealand experience of managing COVID-19 has taught us that capacity is not a steady state measurement. Our approach to response management will adjust as an outbreak evolves, and capacity will be utilised where it will most effectively minimise the risk of onwards transmission.
30. The national capacity expectations, as outlined in this paper, have been modelled from our experience of the national outbreak management approach to date. This has informed the underlying assumptions, including the anticipated case to contact ratio, to provide meaningful and realistic capacity plans.
31. We are considering the workforce capacity in responding to a delta-associated outbreak while rolling out a vaccination.

### Equity

32. Ensuring that New Zealand's contact tracing response is identifying and isolating those who at risk of adverse health outcomes is a key equity consideration.
33. When requiring individuals to isolate, it is important to ensure there are systems in place to support those that need it i.e., food, appropriate accommodation, access to health care services as well as financial support.
34. The NITC continues to work closely with internal teams that are providing DHB-led wrap-around services, as well as the Ministry of Social Development, public health units and local Māori and Pacific providers to ensure the needs of individuals are supported.

### Next steps

35. The National Investigation and Tracing Centre will continue to enhance contact tracing system processes to ensure capacity is available for the appropriate management strategies at each outbreak phase.

ENDS.

# Outbreak Phases and Management Approaches

Phase One: Community cluster(s) (eg, Auckland August 2020 outbreak to current day)	Phase Two: Significant outbreak (eg, New Zealand March/April 2020)	Phase Three: Major outbreak (eg, Melbourne July 2020 & greater)
---	---	--

**Situation:** A single outbreak with geographically contained sub-clusters and low case numbers, contained within 1-4 generations of transmission.

**Situation:** Case numbers have increased significantly across NZ. Multiple separate clusters in a range of settings & new cases that have no known source.

**Situation:** Widespread community transmission. Large numbers of unconnected cases with no known source. Outbreaks causing significant disruption.

**Focus:** Assertive source identification & spread prevention

**Focus:** Outbreak control and community spread reduction

**Focus:** Regain control, minimise hospitalisations & fatalities



Phase One and Two Ready Capacity

Phase Three Surge Capacity

## Outbreak management strategies

The impact of outbreak management strategies vary across the different phases of an outbreak.

Outbreak management strategies	Source investigation	Whole genome sequencing	Contact tracing	Testing	Surveillance testing	Lockdown (short-term preventative)	Lockdown (extended)	Vaccination
Phase One	+++	+	+++	++	++	++	-	-
Phase Two	-	-	+	++	++	-	++	+
Phase Three	-	-	+	+	-	-	+++	++

Key: +++ Significant, ++ Moderate, + Minor, - N/A

**Intervention focus:** As the scale of outbreak increases there is shift from individual interventions to a greater reliance on whole population interventions

## National application of response phases

Example of adaptive response

The response phase can be applied distinctly to each region, relative to the situation in each area.

Phase One  
 Phase Two  
 Phase Three



The New Zealand system response will focus on aligning the appropriate outbreak management strategies to the local situation

# Briefing

## Funding the health system response to COVID-19: report back on health service expenditure to 30 June 2021

<b>Date due to MO:</b>	10 August 2021	<b>Action required by:</b>	N/A
<b>Security level:</b>	IN CONFIDENCE	<b>Health Report:</b>	20211774
<b>To:</b>	Hon Grant Robertson, Minister of Finance Hon Chris Hipkins, Minister for COVID-19 Response		
<b>Copy to:</b>	Hon Andrew Little, Minister of Health		

### Contact for telephone discussion

Name	Position	Telephone
<b>Bridget White</b>	Deputy Chief Executive, COVID-19 Health System Response	s 9(2)(a)
<b>Kevin Davies</b>	Deputy Chief Financial Officer, Corporate Services	s 9(2)(a)

### Minister's office to complete:

- |   |                                    |  |
|---|------------------------------------|--|
| <input type="checkbox"/> Approved             | <input type="checkbox"/> Decline   | <input type="checkbox"/> Noted               |
| <input type="checkbox"/> Needs change         | <input type="checkbox"/> Seen      | <input type="checkbox"/> Overtaken by events |
| <input type="checkbox"/> See Minister's Notes | <input type="checkbox"/> Withdrawn |  |

Comment:

# Funding the health system response to COVID-19: report back on health service expenditure to 30 June 2021

---

**Security level:** IN CONFIDENCE      **Date:** 10 August 2021

---

**To:** Hon Grant Robertson, Minister of Finance  
Hon Chris Hipkins, Minister for COVID-19 Response

---

**Copy to:** Hon Andrew Little, Minister of Health

---

## Purpose of Report

1. This paper provides a report back on health service expenditure for the ongoing health system response to COVID-19 (as requested, CAB-20-MIN-0511 and CAB-21-MIN-0101 refers).
2. It provides an overview of the expenditure incurred across the 2020/21 financial year, a forward-looking view of the 2021/22 financial year, and an overview of potential areas of funding that could be reprioritised to meet other COVID-19 health service response pressures.

## Summary

3. Approximately \$5 billion in operational and capital funding has been invested to date to fund the COVID-19 public health and broader government response.
4. On 2 December 2020, the Cabinet Business Committee (CBC) agreed to an additional \$1,134.046 million over 2020/21 and 2021/22 to support the ongoing health system response to COVID-19 through to 30 June 2022 [CBC-20-MIN-0101 refers].
5. Following this decision, the Ministry of Health (the Ministry) was directed to report back to joint Ministers on the costs of providing health services in Managed Isolation and Quarantine Facilities (MIQFs), and how these are tracking against available funding [CAB-20-MIN-0511 refers].
6. This briefing provides an update on how this funding has been spent and takes the opportunity to extend this report to spending on the full Health COVID-19 health system response spend to date (based on unaudited 30 June 2021 financial results).

## Recommendations

The Ministry of Health recommend that you:

Minister  
for  
COVID-19  
Response

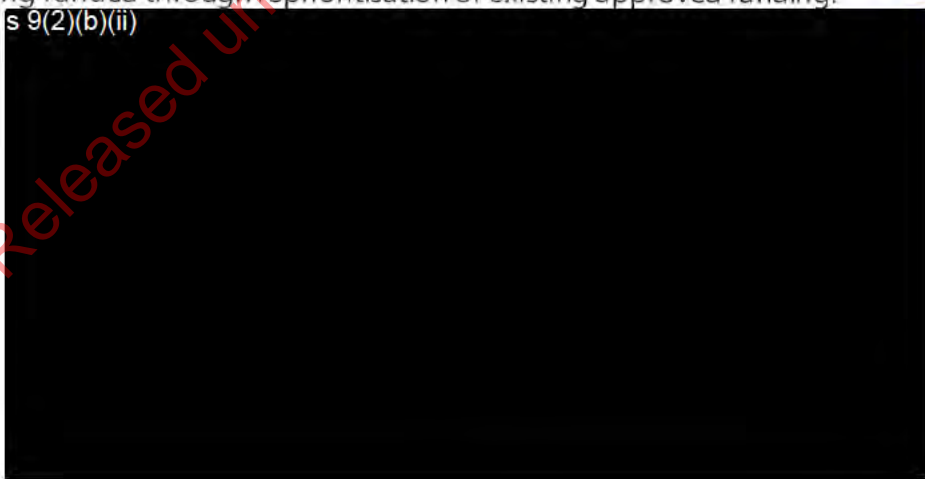
Minister  
of Finance

- a) **Note** that on 2 December 2020, the Cabinet Business Committee (CBC) agreed to an additional \$1,134.046 million over 2020/21 and 2021/22 to support the on-going health system response to COVID-19 through to 30 June 2022.
- b) **Note** that testing is an area where reprioritisation of funding will be sought and a total of \$92.133 million could be available for reprioritisation.
- c) **Note** that laboratory services is an area where reprioritisation of funding will be sought and a total of approximately \$57.274 million is forecast to be available for reprioritisation.
- d) **Note** that the Ministry wishes to retain the funding balance of \$96.857 million within Vote Health for use for the continued health system response to COVID-19 and potential future impacts, and this will be reviewed in a mid-financial year update on actual spend in February 2022
- e) **Note** that in the February 2022 report back, options for the use of the \$96.857 million funding balance will be provided.
- f) **Agree** to the following requirements for the 2021/22 financial year being funded through reprioritisation of existing approved funding:

Yes/No

Yes/No

s 9(2)(b)(ii)



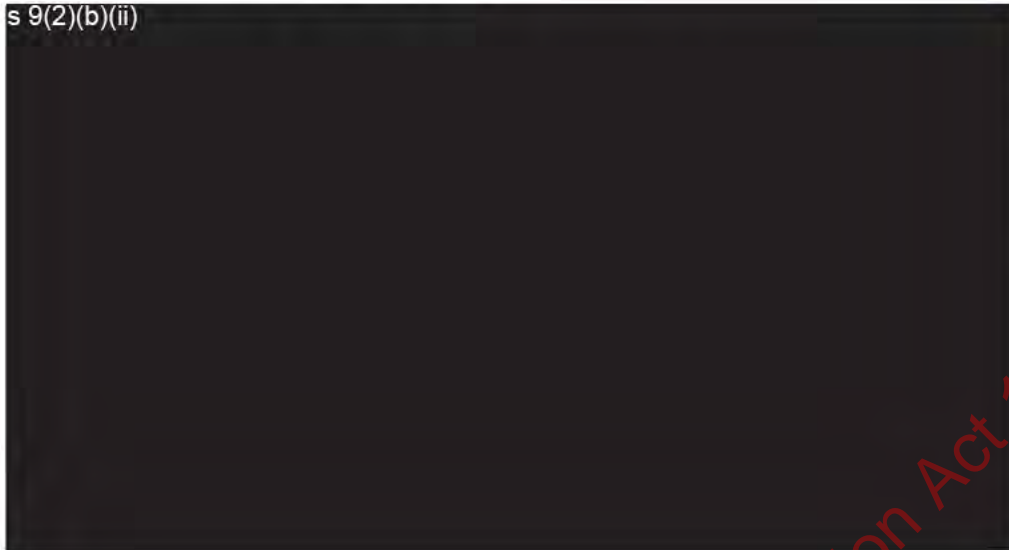


f) **Approve** the following reprioritisations within the Ministry's COVID-19 health system response funding:

Yes/No

Yes/No

s 9(2)(b)(ii)



Bridget White  
Deputy Chief Executive

**COVID-19 Health System Response**

Date: 9/8/21

Hon Chris Hipkins  
**Minister for COVID-19 Response**

Date: 23/8/2021

Hon Grant Robertson  
**Minister of Finance**

Date:

Released under the Official Information Act 1982

# Funding the health system response to COVID-19: report back on health service expenditure to 30 June 2021

## Background

1. Approximately \$5 billion in operational and capital funding has been invested to fund the COVID-19 health system response to date.
2. On 2 December 2020, the Cabinet Business Committee (CBC) agreed to an additional \$1,134.046 million over 2020/21 and 2021/22 to support the on-going health system response to COVID-19 for an 18-month period through to 30 June 2022 [CBC-20-MIN-0101 refers].

Activity area	2020/21	2021/22
	\$ million	\$ million
Community-based testing	89.789	242.908
Laboratory services	61.730	163.520
PPE and supplies	50.000	100.000
Ministry of Health capability for ongoing response to COVID-19	24.596	49.318
DHB capacity to respond to COVID-19	100.000	125.000
Contact tracing	19.000	92.547
COVID-19 Technology capability	2.769	12.869
<b>Gross funding approved</b>	<b>347.884</b>	<b>786.162</b>

3. In December 2020, the Ministry were directed to report back to joint Ministers on the costs of providing health services in MIQ and how these are tracking against available funding [CAB-20-MIN-0511 refers].
4. This briefing provides an update on the following activities continuing to 30 June 2022:
  - a) testing for COVID-19, including swabbing and laboratory services;
  - b) health support for Managed Isolation and Quarantine (MIQ) facilities to ensure controlled entry at the border;
  - c) contact tracing and case management;
  - d) supplies to support the COVID-19 health system response including Personal Proactive Equipment
  - e) key technologies that support the COVID-19 health system response including the COVID-19 Tracer App and the National Contact Tracing Solution (NCTS); and
  - f) public health intelligence (including surveillance).

## Document 3

5. The Minister for COVID-19 Response was also invited to report back within three months of the commencement of Trans-Tasman QFT on how the associated health costs are tracking [CAB-21-MIN-0101 refers].
6. Un-audited financial results are now available for the year ending 30 June 2021, providing an opportunity for reprioritisation of funding to areas of pressure.
7. The COVID-19 health system response continues to be dynamic and rapidly evolving, with a need to adapt in-light of emerging public health evidence and changes in response to virus variants, and apply lessons to identify and strengthen the overall response.

### Health Response Overview

8. Since 23 March 2020, the New Zealand response has been based on an Elimination Strategy; a sustained approach to keep it out, find it and stamp it out. This has required strong control measures, including managed entry at the border, testing and surveillance and contact tracing and contact management. It has also required strong communications to ensure appropriate and accurate information flows to keep the public well informed.
9. In February 2021, New Zealand started rolling out the COVID-19 Vaccine and Immunisation programme (CVIP). This has been integral in maintaining the Elimination Strategy whilst preparing to relax border restrictions to start safely and gradually reconnecting with the world.
10. Emerging evidence and contextual changes have meant that New Zealand has had to rapidly adapt its response throughout, whilst maintaining the Government's ultimate goal of elimination. This has included the emergence of virus variants; including the Delta variant which is more infectious. Ongoing funding is required to enable us to continue to adapt to emerging threats and protect our communities from COVID-19, including changes to our settings and communications to keep the public well informed.
11. Following the completion of the 2019/20 financial year, In-principle Expense and Capital Transfers (IPECTs) totalling \$414.001 million were transferred into 2020/21 at the October Baseline Update (OBU). Almost all this funding has been utilised in the 2020/21 financial year. Due to supply chain and usage timeframes commitments are not being realised as early as previously expected.
12. Total expenditure against available funding for the COVID-19 health system response (2020/21 financial year unaudited) is summarised as follows. Further detail is attached at **appendix 1**.

	<b>Funding 2020/21 \$m</b>	<b>Total Spend 2020/21</b>	<b>Underspend / (Overspend)</b>
COVID-19 Response Directorate	1,398.642	821.085	577.557
COVID-19 Vaccine Immunisation Programme	673.037	375.205	297.832
COVID-19 Wider Response	175.283	130.763	44.520
COVID-19 Response BAU	193.342	193.342	0.000
	<b>2,440.304</b>	<b>1,520.395</b>	<b>919.909</b>

13. Funding from the 2020/21 is expected to be transferred into the 2021/22 financial year, following automatic IPECTs that will be confirmed at the OBU. As the policy settings for the 2021/22 year have not changed from what was originally approved in December 2020, the approved funding for the 2021/22 financial year remain sufficient to cover the funding required. Therefore, the underspend from 2020/21 financial year that has been transferred into the 2021/22 year is unlikely to be required for its existing purposes. Therefore, this paper is highlighting areas where this available funding can be put toward current areas of pressure, while retaining some of this funding for the financial year to manage risks associated with the emergence of the Delta variant, and the rapidly evolving environment.
14. Specific information relating to areas funded to meet the COVID-19 health system response are outlined in the sections below.

## Testing and laboratory services

### Testing

15. Testing volumes to date have been dynamic and this activity and the associated costs of COVID-19 testing activity has depended on the management of outbreaks and policy decisions made, such as mandatory testing regimes for border and MIQ workers.
16. The funding of \$486.902 million for community-based testing over 2020/21 and 2021/22, was secured to maintain base testing capacity at 7,000 tests per day. This level of funding was deemed sufficient to manage fluctuations in need and demand.
17. While there was sufficient testing coverage across New Zealand when New Zealand was free from community cases of COVID-19, following the confirmation of a community case in Northland on 24 January 2021, additional testing stations were provided in the Northland and Auckland regions. On 26 January, the labs processed 10,812 tests; approximately 80% originated in the Auckland and Northland regions.
18. This was our biggest day of testing since the Auckland and Waikato August outbreak in 2020 and demonstrated our testing capacity meeting surges in demand. We continue to see increased testing demand following incidents, such as the New South Wales Quarantine-Free Travel (QFT) case in the Wellington community.
19. Our dedicated testing workforce is now capable of managing 10,000 tests per day nationally routinely, with capacity to flex and increase testing workforce capacity for up to 40,000 swabs per day nationally (sustained for 2 – 3 weeks).

## Document 3

20. A total of 1.485 million tests have been conducted between July 2020 and June 2021. While funding was secured to conduct an average of 5,500 tests per day (for airport and maritime port workers, maritime crew and community through general practice and other designated facilities) at \$121 per test, we are currently conducting an average of 4,069 tests per day, at a cost \$102 per test. This has resulted in an underspend on test collection funding based on price and volume.
21. This is an area where reprioritisation of funding will be sought to redirect this funding to other COVID-19 response work. A total of \$92.133 million could be available for reprioritisation.
22. However, it is expected that policy changes regarding testing modalities and frequency will have an impact on testing volumes and funding, which cannot be quantified until decisions on policy changes are made.
23. Furthermore, with the rapidly evolving environment, the emergence of the Delta variant, and the impact other future variants will have, it is important to note that testing volumes will remain dynamic and funding requirements may change in future. The impact of the increase of Respiratory Syncytial Virus (RSV) cases in New Zealand in 2021 also needs to be considered as individuals presenting with symptoms may be requested to obtain a COVID-19 test.
24. In summary, activity in 2020/21 and forecast in 2021/22 is as follows:

	Testing start date	Forecast end date	Average number of tests per day	Number of testing days	Average cost per test	Costs incurred
					\$	\$ million
Funding agreed to Dec 2020	1/07/2020	31/12/2020	6,926	184	121	154.205
Funding agreed Dec 2020	1/01/2021	30/06/2022	5,500	546	121	363.363
Funding previously reprioritised						(30.667)
Total testing funding to 30 June 2022						486.902
Expenditure incurred as follows:						
Actual Usage (2020/21 unaudited)	1/07/2020	30/06/2021	4,069	365	102	151.861
Remaining funding yet to be spent						335.041
Funding forecast to be committed to 30 June 2022 (based on current policy settings)	1/07/2021	30/06/2022	5,500	365	121	242.908
<b>Potential funding available for reprioritisation</b>						<b>92.133</b>

### Laboratory Services

25. All swabs taken to test for COVID-19 need to be processed by laboratories.
26. The \$320.674 million of funding laboratory processing of tests for the 2020/21 year was secured to process an estimated average of 7,000 tests per day, at an average cost of \$64 per test (down from an average cost of \$70 per test).
27. An average of 5,103 tests per day are currently being processed, at an unchanged average cost of \$64 per test. This has resulted in an underspend at the end of 2020/21 in laboratory processing, based on volume.

28. This is an area where reprioritisation of funding will be sought. A total of approximately \$57.274 million is forecast to be available for reprioritisation.

29. In summary, activity in 2020/21 and forecast in 2021/22 is as follows:

	Testing start date	Forecast end date	Average number of tests per day	Number of testing days	Average cost per test	Costs incurred
					\$	\$ million
Funding agreed to Dec 2020	1/07/2020	31/12/2020	7,409	184	70	95.424
Funding agreed Dec 2020	1/01/2021	30/06/2022	7,000	546	64	244.608
Funding previously reprioritised						(19.358)
Total laboratory funding to 30 June 2022						320.674
Expenditure incurred as follows:						
Actual Usage (2020/21 unaudited)	1/07/2020	30/06/2021	5,103	365	64	119.238
Remaining funding yet to be spent						220.794
Funding forecast to be committed to 30 June 2022 (based on current policy settings)	1/07/2021	30/06/2022	7,000	365	64	163.520
<b>Potential funding available for reprioritisation</b>						<b>57.274</b>

### Saliva Testing

30. In May 2021, the expansion of saliva testing for frontline border workers was announced, and the phased roll-out commenced in June 2021. On 14 July 2021, the Minister for COVID-19 Response announced that border workers would have the choice to provide saliva as a sample for surveillance testing (not diagnosis for COVID-19) to replace their nasopharyngeal testing cycle.

31. A contract with a provider is in place, with a total estimated value of \$60.000 million over 13 months from May 2021. If a wider roll out of saliva testing occurs via the contracted provider, this may result in a decrease in nasopharyngeal swabbing. While saliva testing through the contracted provided is significantly cheaper, the cost impacts of this will be mitigated through an increased frequency of testing.

### Wastewater Testing

32. Wastewater testing is currently being used as a surveillance tool used to detect SARS-CoV-2 RNA in sewage. Analysis of wastewater allows repeat screening of hundreds of thousands of people simultaneously to potentially identify any unrecognised COVID-19 infections in New Zealand.

33. The regular wastewater testing programme is in place in Auckland, Wellington, Christchurch, Rotorua, Hamilton and Queenstown.

34. s 9(2)(b)(ii) of funding is required for operationalisation of wastewater testing nationally for the 2021/22 financial year. This is recommended to be funded through reprioritisation of existing approved funding.

### ESR funding for Surveillance and Testing

35. The Ministry has an annual service agreement with the Institute of Environmental Science and Research (ESR) to provide core health science advice and laboratory services, including public health surveillance and scientific advice, and additional specialist resources for the COVID-19 Response. However, this was not funded into the 2021/22 financial year, and now requires funding.
36. The total contract value for the COVID-19 response component of the ESR contract for financial year 2021/22 will be s 9(2)(b)(ii). This is recommended to be funded through reprioritisation of existing approved funding.

### Supply Chain

#### Personal Protective Equipment (PPE)

37. On-going world-wide disruption of clinical supplies including PPE now needs to be assumed rather than previous assumptions of a sharp spike in demand for a short period followed by normal supply chains post event.
38. The additional funding provided in December 2020 has enabled the Ministry to ensure a 3-month pandemic supply of critical PPE stocks is maintained. There continues to be sufficient stock of PPE supplies in New Zealand, stocks of all items have continued to arrive regularly, and additional orders continue to be placed as required.
39. The focus on PPE seen early in the response to COVID-19 has now shifted to a focus on ensuring an adequate supply of critical medical supplies.

#### Critical Medical Supplies

40. The centralised supply chain function established by the Ministry early in the response to COVID-19 has successfully been used to address these shortages of critical medical supplies. While these supplies are not always used to respond to COVID-19, the shortages are more often than not a direct result of the pandemic's impact on supply chains.
41. The centralised function has successfully sourced and distributed a range of critical medical supplies that have allowed patient care to continue, including infusion pumps, sterile wrap, and blood tubes.
42. The Ministry is currently utilising the PPE funding to maintain critical medical supplies, and is piloting a new operating model for centrally managing critical medical supplies. The Ministry expects this to be operationalised later this year.

#### Air filtration in MIQ facilities

43. Since December 2020, the Ministry has funded air filtration units for MIQ facilities (\$5.7 million). Additional funding of s 9(2)(b)(ii) is needed to complete the shared space roll out and servicing all air filtration units across MIQ facilities and installing air filtration units in remaining swabbing rooms for a two-year period, is recommended to be funded through reprioritisation of existing approved funding.

44. The Ministry of Business Innovation and Employment (MBIE) has operational and management responsibility for MIQ facilities as well as the ongoing ventilation work. As such, it is likely that any further funding is owned by MBIE in order to progress the air filtration work programme.

## Contact Tracing

45. Funding for contact tracing to date has been used to maintain National Investigation and Tracing Centre (NITC) operational capacity and function, ensure distribution of health system response funding to Public Health Units (PHUs), maintain call centre capacity and deliver enhancements to the National Contact Tracing Solution (NCTS) - the information technology platform used to manage cases, contacts and travellers. The NCTS is key to national co-ordination of contact tracing and has supported the building of further surge capacity.
46. The funding to PHUs has been used to strengthen the national public health capability to respond to cases, contacts and outbreaks. It has supported the National Outbreak Response Team, as well as several initiatives, to strengthen national coordination and leadership across the sector.
47. The Ministry funds two organisations to provide call centre support for contact tracing - Whakarongorau Aotearoa New Zealand Telehealth Services LP (previously known as Homecare Medical (New Zealand) Limited Partnership) and Healthstat Limited (CBG).
48. Initially, the funding included receiving and making calls relating directly to contact tracing and COVID-19 enquiries only. However, it has since been recognised that COVID-19 has impacted several other services and additional funding of s 9(2)(b)(ii) for the FY2021/22 is needed to support increased volumes of calls to core Healthline, border digitisation, processing of border exemptions and to include a dedicated support line for other clinicians. It's recommended this be funded through reprioritisation of existing approved funding.

## Health Services at the Border

### Managed Isolation and Quarantine

49. Since 26 March 2020, 159,583 people have been through our MIQ facilities (as at 31 July 2021). This includes a total of 125,278 people from July 2020 to June 2021.
50. Funding on 7 December 2020, following reference from the Cabinet Business Committee, Cabinet agreed to fund health wraparound services for guests in Managed Isolation and Quarantine (MIQ) for 18 months (to end of June 2022) totalling \$191.100 million [CAB-20-MIN-0511 refers].
51. Funding for the health wraparound services was secured to support an estimated average of 7,000 guests per day through Managed Isolation and Quarantine Facilities (MIQFs), at an average cost of \$50 per guest per day. However, an average of 4,836 guests per day have been processed between 1 January 2021 and 30 June 2021, costing on average \$24 per guest per day. This has resulted in an underspend in MIQF health services, based on price and volume.



52. Additional costs from DHBs associated with MIQF health services in 2020/21 are still expected. . Technology costs are also not fully accounted for in the current calculations and are expected in the 2021/22 year. It is therefore that recommended that the current available funding not yet allocated be offered for reprioritisation.

MIQ	MIQ start date	Forecast end date	Average number of guests per day	Number of days	Average cost per guest	Costs incurred
					\$	\$ million
Full year funding	1/01/2021	30/06/2022	7,000	546	50	191.100
Expenditure incurred as follows:						
Actual Usage (2020/21 unaudited)	1/01/2021	30/06/2021	4,836	181	24	21.260
Remaining funding yet to be spent						169.840
Funding forecast to be committed to 30 June 2022 (based on current policy settings)	1/07/2021	30/06/2022	7,000	365	50	127.750
<b>Potential funding underspend</b>						<b>42.090</b>

53. The Department of Prime Minister and Cabinet (DPMC) are currently leading a programme of work on self-isolation trials. This work is to test the systems and processes that could be used for reconnecting New Zealanders. It should therefore be a scalable model that may be suitable for use for some travellers under the Reconnecting New Zealand work programme.
54. The Ministry of Health will set the health measures required for self-isolation. It will have different costs for individuals and Government due to still to be defined requirements on the health workforce (at the border and in the community), transfers to accommodation, and mobile testing. These costs are not yet quantified but are likely lower than MIQ stays.
55. Pilot options will be presented to Cabinet as part of the August Reconnecting New Zealand Cabinet paper. Final decisions can be delegated to the Reconnecting New Zealand Ministerial Group, and the pilot could occur in November this year.

### Health Order Exemptions

56. It is being proposed that the Ministry's Border and Managed Isolation team expand its existing function to cover border related operational policy activities, including responding to and managing the process for ministerial exemptions under the Air Border Order (ABO) and Maritime Border Order.
57. The next update of the ABO in August 2021 is also expected to increase the number of applications for ministerial exemptions. This will likely increase in volume over time should border settings continue to change.

### Quarantine Free Travel (QFT)

58. On 24 March 2021, one-way QFT from Niue to New Zealand commenced. From 11.59pm 18 April 2021, QFT commenced for passengers between Australia and New Zealand. This was followed by the commencement of QFT for passengers between New Zealand and the Cook Islands on 17 May 2021.

59. s 9(2)(b)(ii)

a

b

c

60. The Minister for COVID-19 Response was invited to report back within three months of the commencement of Trans-Tasman QFT on how the associated health costs are tracking [CAB-21-MIN-0101] refers. The Ministry is working with DHBs to develop a granular breakdown of QFT costs, however this work is not expected to be completed until the end of 2021.

61. Current funding is expected to be able to cover current MIQ, Border and QFT costs within existing settings. If further airports are designated as suitable for QFT, and if New Zealand commences QFT with other countries, this will likely result in increased costs.

62. Opening our borders and commencing QFT carries a level of risk. Given our knowledge of health risks, ongoing risk management mechanisms and border measures have been put in place. Due to the need to respond quickly to evolving situations, it is expected that although the current level of funding is sufficient, any additional public health measures required as part of QFT arrangements may place additional pressure on funding.

Released under the Official Information Act 1982

## Research

63. The Ministry currently has several pieces of commissioned research work underway and several proposed areas for further research work, broad categories and estimated costs are illustrated below:

Research Name	Purpose	Estimated cost
Modelling	Transmission Modelling- Understanding impact of vaccination and changes in border control measures  Scenario tree modelling A statistically valid model to understand absence of SARS-CoV-2 in a given population  Asymptomatic testing sampling methodology  Seroprevalence Survey	s 9(2)(b)(ii)
Databases – access to current information sources	Support access to emerging science on a range of topics  Surveillance software	
Trials/Pilots/Proof of Concepts	Testing and evaluating changes to current response settings e.g. managed isolation, testing frequency	
Cohort Study	Long term study to understand short and long-term physical, psychological, and economic impacts of COVID-19 on affected people in Aotearoa New Zealand	
Behavioural Insights Research	Effectiveness of control measures, behavioural influences on adhering to control measures, barriers to accessing testing; isolation options and other essential COVID services monitor changes in public knowledge, understanding and behaviour.	
Monitoring and Evaluation	Effectiveness of surveillance activities (eg wastewater testing)	
<b>Total</b>		

64. An agreement is sought to fund these initiatives through reprioritisation of existing approved funding.

## Funding health system capacity

### COVID-19 Health System Response Directorate

65. The Ministry's operating model has evolved significantly since the emergence of the COVID-19 pandemic which has generated new responsibilities, functions, and services for the Ministry to undertake.

66. To avoid compromising the Ministry's non-COVID-19 work programme, a dedicated COVID-19 Health System Response Directorate was implemented that incorporated contact tracing, testing, national supply management and the health-related aspects of managed isolation and quarantine to work alongside the national leadership, co-ordination and incident management functions of the Ministry and sector, as well as dedicated public health intelligence and science advice functions. The CVIP programme was also established for the rollout of the COVID-19 vaccine.
67. The Directorate has been designed to be largely self-contained and operates sustainably. The Ministry has also needed to resource a permanent COVID-19 System Strategy and Policy group with enough capacity to meet ongoing demand alongside delivering on other Government priorities and requirements.
68. The Ministry had been funded \$95.287 million for its COVID-19 health system response to 30 June 2022, as it remained clear that a response to COVID-19 would be a feature for some time to come. Additional funding provided in December 2020 has supported the Ministry to establish fixed-term positions, reduce reliance on more expensive contractors, and to manage the health, safety and wellbeing of staff servicing the rapid turnaround work required. The 2020/21 spend was \$34.054 million (unaudited as at 30 June 2021).
69. However, there is risk associated with the establishment of fixed term contracts through to 30 June 2022. The impact of the Health and Disability System Reforms could result in the loss of fixed term staff before this time, which will see a loss of knowledge and expertise, and an over-reliance on contractors seen early in the response.
70. Other work programmes around the wider Ministry continue to support, and are integral to, the COVID-19 health system response. This includes the Māori Health team, the Pacific Health team, and the Population Health and Prevention and Office of the Director-General directorates.
71. DPMC are leading a programme of work looking at the COVID-19 response beyond 30 June 2022.

### **District Health Board (DHB) COVID-19 related costs**

72. DHBs are an essential part of the health system COVID-19 health system response. However, there is an ongoing expectation that DHBs will implement and fund additional COVID-19 related activities as required, often at very short notice.
73. Whilst under higher alert levels DHBs paused business as usual services to address the requirements of the response, DHBs have subsequently worked hard to deliver and catch up on services delayed earlier in the pandemic. DHBs and primary care providers have also been asked to continue focusing on reducing barriers to access testing, for Māori and Pacific communities in particular.
74. A long-term approach for DHB COVID-19 responsiveness and capability needed to be in place and resourced, particularly the likelihood of continuing to require emergency response and co-ordination functions. The additional \$225.000 million provided in December 2020 has addressed some of these COVID-19 related costs and avoided these costs being incremental additions to DHB deficit positions.

## Document 3

75. This funding has been distributed on an as-needed basis to DHBs based upon the regular reporting received by the Ministry detailing unfunded COVID-19 related costs.
76. While funding for DHB COVID-19 related costs is deemed to be sufficient for the 2021/22 financial year, it is important to note that workforce and system capacity issues continue to be of concern. The capacity and capability of the health workforce to respond to COVID-19 is central to New Zealand's response and readiness for COVID-19 (HR20211415 refers).
77. It is important that consideration is given to DHB capacity and capability to not only continue responding to COVID-19, but to respond to other pressures. For example, the recent surge in RSV cases.
78. While DHBs employ the majority of the health workforce engaged in the COVID-19 response and are responsible for addressing capacity, capability issues and occupational health and safety issues, the Ministry, as steward of the health system is actively engaged in supporting and guiding the future direction of the workforce.

### COVID-19 Technology

79. Technology has been a core part of the COVID-19 health system response to date including consumer level applications to assist in contact tracing and data management solutions to support co-ordinated activity nationally.
80. The COVID-19 technology investment of \$111.139 million which includes funding for the replacement of NIS of \$38.000 million (but excluding CVIP technology funding) has enabled us to continue to run, maintain and develop technology to support the COVID-19 health system response into 2021/22.
81. The past year has seen the creation of an extraordinary range of technologies and tools to support New Zealand's COVID-19 health system response, working in partnership with the sector and suppliers.

System	Description
<b>National Contact Tracing System (NCTS)</b>	The NCTS provides a national system used by all Public Health Units rather than the previous separate systems and has the ability to scale up contact tracing rapidly as needed. NCTS records interactions between individuals identified as cases, close contacts or casual contacts and PHUs or the Ministry.
<b>Border Management and Workforce Testing Register</b>	The Register enables the Ministry of Business, Innovation and Employment (MBIE), the Ministry of Health, and any border employer to view the status of regular testing and vaccination status of their workforce. It sends emails and texts to employees who have missed a test. Employers can see reporting data and identify individuals requiring follow up.
<b>MIQ Patient Management System</b>	Many people in managed isolation and quarantine (MIQ) facilities have other health needs. The Ministry developed a clinical records system for health professionals on site to undertake assessments, document interventions and advise the person's registered GP.

System	Description
<b>COVID-19 Immunisation</b>	The COVID-19 Immunisation Register (CIR) records every COVID-19 vaccination, a national online booking system will make it easy to schedule vaccination bookings, as well as systems for vaccine distribution and adverse event monitoring. Consumer channels (phone, digital) are also being developed.
<b>NZ COVID Tracer App</b>	The app speeds up contact tracing by collecting information about where people have been and by collecting information about contacts (anonymously exchanging Bluetooth keys). Data is private until a user chooses to share it. There are now more than 2.8 million users.
<b>Sponsored data</b>	The Ministry and mobile network operators collaborate to offer free access to essential health information and digital health services, including COVID-19 information.
<b>NZ ePrescription Service</b>	The NZ ePrescription Service provides a secure messaging channel for prescribing and dispensing systems to exchange prescription information. The Ministry has made it easier to provide electronic prescriptions to support virtual care by removing the need for paper.
<b>Āwhina app</b>	Allows health workers to receive updated information from the Ministry on the COVID-19 health system response.
<b>Testing and results management</b>	Clinical information about PCR tests is needed as part of MIQ. Tests must be transported to the lab and results returned to the MIQ Patient Management System. The Ministry has developed new systems to support this nationally.
<b>Data and analytics</b>	Data have been used to support the COVID-19 health system response, including for border, virus surveillance, and vaccines. A data and analytics platform has been developed to support the Ministry and sector's surveillance efforts, which enables the Ministry to share a national view of COVID-19 insights and data. This platform has reduced demands on DHBs for their own reporting and analytics and has established a base for extension to other communicable diseases.

82. The Ministry's Data and Digital team are working on proposed investment pathways for the COVID-19 technology solutions that have been developed, and a further budget bid is expected to allow for continual use of this investment.


### COVID-19 Vaccine Immunisation Programme

83. The COVID-19 Vaccine Immunisation programme reported back to Cabinet [CAB-21-MIN-0229 refers] on progress in this area, with no further updates available for this briefing.

## Summary of Funding Pressures to be reprioritised

84. It is proposed that the following funding is reprioritised within the Ministry's COVID-19 health system response funding to continue supporting the work noted above.

s 9(2)(b)(ii)



85. The Ministry wishes to retain the funding balance of \$88.557 million for use for the continued health system response to COVID-19 and potential future impacts.

### Future focus

86. The COVID-19 Directorate's Operational and Policy functions have progressed a programme of work on updating the elimination strategy and contributing to the All of Government work on reconnecting New Zealand to the rest of the world.
87. The Ministry has work underway looking at how we transition the health workforce and necessary services into the wider public health system, alongside the Health and Disability System Review reforms. This includes embedding the legacy of the health response to COVID-19, including the capability of the workforce, into the wider health system, and solidifying the learnings, practices and achievements for future potential communicable disease outbreaks.
88. For example, it is expected that current COVID-19 technological capability and systems used for New Zealand's response to COVID-19 will be built for ongoing use. The Ministry is looking at a strategic approach to how technology solutions developed for the response could be used for future developments.
89. Due to emerging evidence and contextual changes, such as the emergence of the highly transmissible Delta variant, it is expected that a plan for managing COVID-19 past current funding to the end of June 2022 will be needed. Ongoing funding will be required to enable us to continue to adapt to emerging threats and protect our communities from COVID-19, including changes to our settings and communications to keep the public well informed.
90. As testing technology changes there is likely to be a demand for methods that enable test results to be returned closer to the time of arrival and departure of travellers, such as point-of-care testing and more rapid tests. It is expected that any change in test type and frequency or sequence will be funded via a reprioritisation of existing funds.

**Next steps**

91. Subject to your approval, the Ministry will reprioritise unallocated funding already provided for within the Ministry's COVID-19 health system response to continue the health system response to COVID-19 and potential future impacts.
92. The Ministry will provide a mid-financial year update on actual spend in February 2022.

**ENDS.**

Released under the Official Information Act 1982



## Appendix 1

Initiative - COVID-19 Response Directorate		Funding 2020/21 \$m	Total Spend 2020/21	Underspend / (Overspend)
COVID-19 Directorate	DHB capacity to respond to COVID-19	140.000	40.791	99.209
	Ministry of Health costs, including support for NCMC	45.969	34.734	11.235
Testing & Supply	Personal Protection Equipment (PPE) & Equipment	464.625	211.557	253.068
	COVID-19 Surveillance Plan and Testing Strategy - Laboratory Services	180.585	128.443	52.142
Contact Tracing	COVID-19 Surveillance Plan and Testing Strategy - Testing	244.994	151.861	93.133
	Implement a comprehensive approach to contact tracing	73.119	60.851	12.268
Border & MIQ	Enhanced border measures – managed isolation and quarantine	249.350	192.848	56.502
<b>Total COVID-19 Response Directorate</b>		<b>1,398.642</b>	<b>821.085</b>	<b>577.557</b>

Initiative - COVID-19 Vaccine Immunisation Programme		Funding 2020/21 \$m	Total Spend 2020/21	Underspend / (Overspend)
CVIP	COVID-19 Vaccine Programme	216.730	143.851	72.879
	COVID-19 Vaccine Purchase	456.307	231.354	224.953
<b>Total COVID-19 Vaccine Immunisation Programme</b>		<b>673.037</b>	<b>375.205</b>	<b>297.832</b>

Initiative - COVID-19 Wider Ministry Response		Funding 2020/21 \$m	Total Spend 2020/21	Underspend / (Overspend)
Ministry Wider Response	Pacific Response Package	20.977	14.888	6.089
	National Immunisation System	11.927	0.008	11.919
	Boosting the Healthline COVID 19 response (Telehealth)	29.164	29.163	0.001
	Increase in Combine Pharmaceutical Budget and PHARMAC operating costs	50.000	50.000	0.000
	COVID-19 Response: Technology and Services	24.029	15.195	8.834
	Others	39.186	21.508	17.678
<b>Total COVID-19 Wider Response</b>		<b>175.283</b>	<b>130.763</b>	<b>44.520</b>

Initiative - COVID-19 Ministry BAU Response		Funding 2020/21 \$m	Total Spend 2020/21	Underspend / (Overspend)
Other	Planned care – COVID-19 Backlog, Maternity Action Plan, New Zealand Blood Service: Impacts of COVID-19 & Others	193.342	193.342	0.000
<b>Total COVID-19 Response BAU</b>		<b>193.342</b>	<b>193.342</b>	<b>0.000</b>

		Funding 2020/21 \$m	Total Spend 2020/21	Underspend / (Overspend)
Total COVID-19 Response Directorate		1,398.642	821.085	577.557
Total COVID-19 Vaccine Immunisation Programme		673.037	375.205	297.832
Total COVID-19 Wider Response		175.283	130.763	44.520
Total COVID-19 Response BAU		193.342	193.342	0.000
<b>Total</b>		<b>2,440.304</b>	<b>1,520.395</b>	<b>919.909</b>

Initiative - COVID-19 Contingencies		Funding 2020/21 \$m
Directorate	Minimising the health impacts of COVID-19 Tagged Operating Contingency (Vaccine)	369.374
<b>Total COVID-19 Contingencies</b>		<b>369.374</b>

# Briefing

## COVID-19 Alert Level public health advice: Auckland community case

**Date due to MO:** 17 August 2021      **Action required by:** 17 August 2021

**Security level:** IN CONFIDENCE      **Health Report number:** 20211889

**To:** Hon Chris Hipkins, Minister for COVID-19 Response

**Copy to** Rt Hon Jacinda Ardern, Prime Minister  
 Hon Andrew Little, Minister of Health  
 Hon Kris Faafoi, Minister of Justice

### Contact for telephone discussion

Name	Position	Telephone
<b>Dr Ashley Bloomfield</b>	Te Tumu Whakarae mō te Hauora Director-General of Health	s 9(2)(a)
<b>Maree Roberts</b>	Deputy Director-General System Strategy and Policy	

### Minister's office to complete:

- |   |                                    |  |
|---|------------------------------------|--|
| <input type="checkbox"/> Approved             | <input type="checkbox"/> Decline   | <input type="checkbox"/> Noted               |
| <input type="checkbox"/> Needs change         | <input type="checkbox"/> Seen      | <input type="checkbox"/> Overtaken by events |
| <input type="checkbox"/> See Minister's Notes | <input type="checkbox"/> Withdrawn |  |

Comment:

# COVID-19 Alert Level public health advice: Auckland community case

---

**Security level:** IN CONFIDENCE                      **Date:** 17 August 2021

---

**To:** Hon Chris Hipkins, Minister for COVID-19 Response

---

## Purpose of report

1. Following my verbal update provided to Cabinet on Tuesday 17 August 2021, this report provides further advice on the emerging risk of COVID-19 community transmission. In summary, I recommend that you move Auckland and the Coromandel Peninsula to Alert Level 4 for one week and the rest of the country for at least 72 hours from 11.59pm on Tuesday 17 August.

## Summary

2. On Tuesday 17 August 2021 the Ministry of Health was informed of a confirmed new COVID-19 community case in Devonport, Auckland (Case A). Until it is confirmed otherwise, officials assume it is the Delta variant.
3. The source of infection is still unclear and is under investigation. Whole genome sequencing results are not yet available. One line of investigation is that the source might be from two of Case A's colleagues that reported illnesses during July. These colleagues are being tested.
4. Case A is considered to have been infectious since Thursday 12 August, became symptomatic on Saturday 14 August, and felt unwell on Sunday 15 August. On Monday 16 August, he developed a cough and other symptoms and was tested at the Devonport Medical Centre.
5. The doctor who tested Case A was in full personal protective equipment (PPE) and Case A entered the medical centre via the rear entrance, avoiding other patients.
6. There are currently ten exposure events, including locations of interest across Auckland and at 13 in the Coromandel Peninsula. The latter includes a crowded hotel bar in where Case A watched the Bledisloe rugby test match. Case A was a frequent user of the COVID-19 Tracer App.
7. Given the unknown source of this case, the number of locations of interest, and the period Case A was infectious, I cannot rule out the possibility of wider community transmission.
8. Based on the available evidence at 5pm today **I recommend that Auckland and the Coromandel Peninsula should move to Alert Level 4 for one week and the rest of the country for at least 72 hours from 11.59pm on Tuesday 17 August.**

## Recommendations

We recommend that you:

- a) **Note** my advice as the Director-General of Health on the prerequisites for making an Order under the COVID-19 Public Health Response Act 2020, including: **Noted**
- i) the risks of an outbreak or spread of COVID-19
  - ii) the nature and extent of measures that are appropriate to address those risks.
- b) **Note** my public health advice is to move Auckland and the Coromandel Peninsula to Alert Level 4 for an initial period of seven-days and the rest of the New Zealand for at least 72 hours from 11.59pm on 17 August 2021. **Noted**
- c) **Note** that my advice as the Director-General of Health is that COVID-19 Public Health Response (Alert Level Requirements) Order (No 9) 2021 for signing is in line with the purpose of the COVID-19 Public Health Response Act 2020 to prevent, and limit the risk of, the outbreak or spread of COVID-19 by implementing appropriate public health measures. **Noted**
- d) **Note** that the Ministry of Health will continue to review the situation and our advice based on ongoing case investigations and testing. **Noted**



Dr Ashley Bloomfield  
**Te Tumu Whakarae mō te Hauora**  
**Director-General of Health**

Date: 17 August 2021

Hon Chris Hipkins  
**Minister for COVID-19 Response**

Date:

# COVID-19 Alert Level public health advice: Auckland community case

## Background

9. On the afternoon of 17 August, Cabinet met to discuss Alert Level settings to address the risk of COVID-19 transmission posed by this new community case in Auckland. I provided a verbal update based on the information available at that time.

## Case information

10. On Tuesday 17 August 2021 the Ministry of Health was informed of a confirmed new COVID-19 community case in Devonport, Auckland (Case A). Until it is confirmed, officials assume it is the Delta variant.

s 9(2)(a)

Released under the Official Information Act 1982

16. Testing teams are on stand-by to set up testing stations as required including arranging extended hours for the evening of 17 August. This will include pop up testing sites in Devonport, Auckland. Testing levels in Auckland have been steady the previous few weeks.
17. There is reasonable managed isolation and quarantine (MIQ) capacity dependent on where the contacts and/or future cases will need to be isolated or quarantined. As of 17 August, of the 189 quarantine rooms available across the country, 129 are in Jet Park, Auckland.

## Public health advice

18. Given the unknown source of Case A's infection and no obvious link to the border, the number of locations of interest, and the transmissibility of the Delta variant, I cannot rule out the possibility of wider community transmission at this stage.
19. To minimise the risk of further undetected transmission, an Alert Level change is required to stop the movement of any potential contacts of Case A and other potential chains of transmission.
20. Based on the available evidence at 5pm today and consistent with our 'early aggressive approach', my advice is that **you should move Auckland and the Coromandel Peninsula to Alert Level 4 for an initial period of seven days and the rest of the country for at least 72 hours from 11.59pm on Tuesday 17 August 2021.**
21. If a source or chains of transmission can be shown to be isolated these Alert Levels could be reduced quickly, informed by the most recent information at the time.
22. I consider a move to Alert Level 4 is proportionate due to the:
  - a. lack of a confirmed source of infection currently and possible as-yet-undetected chains of transmission
  - b. transmissibility risk of the Delta variant
  - c. high number of locations of interest across the Auckland and Coromandel region
  - d. risk that the virus has travelled outside of Auckland and the Coromandel Peninsula and that lines of transmission outside of that area have not yet been ruled out
  - e. consistency with wider public messaging on the response to a Delta variant outbreak.
23. It is important to note that this approach will mean a slowdown of the COVID-19 vaccination as vaccinations will need to be paused initially at Alert Level 4. A safe restart under Alert Level 4 can however be planned and be implemented, while avoiding any potential further community transmission in the short-term.
24. I consider that return travel from quarantine-free travel countries (the Cook Islands and one-way travel from Niue) can continue during this period. Those returning to New Zealand will need to adhere to all relevant Alert Level 4 restrictions.
25. We will issue a new Direction under section 70 of the Health Act 1956 to mitigate the public health risk who have been at any location of interest. This will place legal obligations on people to contact Healthline, get a test, and isolate.
26. I did consider a move to Alert Level 4 for Auckland and the Coromandel Peninsula and Alert Level 3 for the rest of the country. However, noting the above points, I do not consider it an appropriate response given the risk posed by this community case of COVID-19 at this time.
27. I also considered a move to Alert Level 4 for the North Island and a lower Alert Level for the South Island. However, this would not have been logical as people have been travelling freely in and out of Auckland during the period prior to Case A's infection being identified.

## Factors to consider when making decisions about COVID-19 Alert Levels

28. The public health factors to be considered when making decisions about COVID-19 Alert Levels were agreed by Cabinet on 4 May 2020 [CAB-20-MIN-0199 refers]. These factors continue to be relevant in the context of the new outbreak. They are my degree of confidence that:
- transmission is restricted to households and known clusters
  - testing and contact tracing capacity is adequate
  - border control and isolation measures are robust
  - there is sufficient health and disability system capacity to manage COVID-19 cases, including adequate PPE for people for whom it is recommended.
29. Cabinet also agreed three other factors:
- evidence of the effects of the measures on the economy and society more broadly
  - evidence of the impacts of the measures for at risk populations
  - our ability to operationalise the restrictions, including satisfactory implementation planning.
30. The National Response Leadership Team will advise Cabinet separately on these factors.

## Equity

31. There are two factors to balance in considering equity implications:
- we know from historical examples that Māori and Pacific peoples are likely to be disproportionately affected by a widespread epidemic
  - we also know these communities are also likely to be disproportionately affected by the impact of any controls, for example, they are less likely to be able to work remotely.
32. The moves that have been taken to control the outbreak strongly and quickly are intended to prevent the spread of COVID-19 to all New Zealanders, including these vulnerable populations. As such, the measures are intended to promote equity of health outcomes. We note that imposing restrictions to achieve better health outcomes could involve worse economic outcomes for vulnerable populations in the short term.
33. As the risk of community transmission abates, the relaxation of the temporary controls and restrictions on gathering sizes will reduce the impact of controls and therefore the impact on equity (e.g. in terms of any economic harms involved).

## Next steps

34. Investigation of this case will continue, and I will review my advice regularly as new information becomes available and keep you informed.

**ENDS.**



# Joint Briefing

## Approach to managed isolation and quarantine for community cases and close contacts

<b>Date due to MO:</b>	N/A	<b>Action required by:</b>	N/A
<b>Security level:</b>	IN CONFIDENCE	<b>Health Report:</b>	20211926
		<b>MBIE Report:</b>	NZ-002
<b>To:</b>	Hon Chris Hipkins, Minister COVID-19 Response		

### Contact for telephone discussion

Name	Position	Telephone
<b>Maree Roberts</b>	Deputy Director-General, System Strategy and Policy, Ministry of Health	s 9(2)(a)
<b>Megan Main</b>	Deputy Secretary, MIQ, Ministry of Business, Innovation and Employment	s 9(2)(a)

### Minister's office to complete:

- |   |                                    |  |
|---|------------------------------------|--|
| <input type="checkbox"/> Approved             | <input type="checkbox"/> Decline   | <input type="checkbox"/> Noted               |
| <input type="checkbox"/> Needs change         | <input type="checkbox"/> Seen      | <input type="checkbox"/> Overtaken by events |
| <input type="checkbox"/> See Minister's Notes | <input type="checkbox"/> Withdrawn |  |

Comment:



# Approach to isolation and quarantine for community cases and close contacts

---

**Security level:** IN CONFIDENCE      **Date:** 23 August 2021

---

**To:** Hon Chris Hipkins, Minister for COVID-19 Response

---

## Purpose of report

1. This briefing provides advice on the current isolation and quarantine situation for community cases and close contacts and seeks confirmation of ongoing settings, particularly in light of the Delta variant and its operational implications.

## Summary

2. The level of COVID-19 in the community and the associated close contacts are placing pressure on quarantine and isolation settings. This is due to the rise in the number of community cases and close contacts that require management.
3. We are seeking confirmation that you are comfortable with the current settings for quarantine and isolation for community cases and close contacts. Ongoing clarity is required to maintain an effective and consistent response.
4. We are proposing that positive community cases continue to be managed in managed quarantine facilities where it is deemed safe and appropriate to do so. Close contacts continue to remain in the community where it is deemed safe and appropriate to do so. In some instances, Medical Officers of Health may require a close contact to isolate in a managed isolation facility. To assist MBIE with forward planning and certainty, we propose that up to 100 spaces are reserved (tagged) in Managed Isolation and Quarantine Facilities (MIQF) for this purpose. In preparation for the likely event that this capacity will be reached, MBIE and Health officials are working together to develop options for alternate arrangements.
5. We intend to update guidance and communications to reconfirm the continued approach to managing community cases and close contacts, including arrangements for safely transporting cases and close contacts, to ensure an efficient response.

## Recommendations

We recommend you:

- a) **Note** that the current rise in COVID-19 cases in the community and the increased transmissibility of the Delta variant means we need to review our approach and accountabilities for management of community cases and close contacts.

## Document 6



- b) **Note** the current pressure and constraints on managed isolation and quarantine capacity and the expected increase in community cases needing to enter quarantine facilities in the next few days.
- c) **Agree** that 100 spaces are reserved (tagged) in the MIQ system for community close contacts in order to manage capacity impact across the system and support the provision of quarantine spaces for positive community cases. **Yes/No**
- d) **Note** that in preparation for the likely event that this capacity will be reached, MBIE and Health officials are working together to develop options for alternate arrangements.
- e) **Confirm** that managed quarantine facilities will remain the default for community cases, where it is deemed safe and appropriate to do so. **Yes/No**
- f) **Confirm** community close contacts will be managed in the community by local DHBs, where it is deemed safe and appropriate to do so. **Yes/No**
- g) **Note** the Ministry of Business, Innovation and Employment, the Ministry of Health and other relevant government agencies will work together to model scenarios to plan for immediate demand on managed quarantine and isolation facilities.
- h) **Note** that DHBs will continue to manage travel for cases within their regions and MBIE will continue to manage travel inter-regionally.
- i) **Note** we will develop guidance and communications to re-confirm and support these decisions.

Dr Ashley Bloomfield  
Te Tumu Whakarae mō te Hauora  
Director-General

**Ministry of Health**

Date:

Megan Main  
Deputy Secretary, MIQ

**Ministry of Business, Innovation and  
Employment**

Date: 25 August 2021

Hon Chris Hipkins

**Minister for COVID-19 response**

Date:

# Approach to Managed isolation and quarantine for community cases and close contacts

## Background and context

6. The current outbreak of COVID-19 and consequent rise in cases in the community and the increased transmissibility of the Delta variant has meant that we need to consider how we can enhance our current approach to managing community cases and their close contacts.
7. To date, positive community cases are typically directed by Medical Officers of Health to enter MIQF under section 70 of the Health Act 1956, unless the Medical Officer of Health deems that there is a strong case for an alternate arrangement.
8. The close contacts of cases are normally expected to isolate at home, unless otherwise directed by a Medical Officer of Health. In these cases, additional support is provided where required through an all-of-government response coordinated by DHBs with support from MSD and other welfare agencies and organisations.
9. In certain circumstances, alternative local community isolation accommodation may be offered or required if the usual place of residence is not suitable. It is important to note that a priority is placed not to split 'bubbles' or family groupings, and this will be considered in identifying appropriate quarantine or isolation arrangements.
10. The recent outbreak of COVID-19 in the community has led to the need to revisit key issues:
  - a. What is the on-going impact of using managed isolation and quarantine facilities for community cases and some close contacts and how do we manage the impact this has on the availability of appropriate spaces within Managed Isolation and Quarantine Facilities for both community cases and scheduled international arrivals?
  - b. What should happen to close contacts of community cases where they need to isolate or quarantine?
  - c. How do we ensure safe transport of cases to managed quarantine facilities?

## Issue 1: The rise of community cases is placing pressure on managed isolation and quarantine capacity

### *Current context:*

11. During this current outbreak, the direction has been that positive community cases should go into a managed quarantine facility wherever safe. Spaces in MIQF are limited and the system is being placed under pressure by the increase in community cases. MBIE provided separate advice to you on this issue [MBIE briefing NZ001 refers].



12. MBIE have already expanded quarantine capacity in Wellington and are in the process of assessing options for a second quarantine facility in Auckland. Current modelling indicates that this facility will be required in the next 2-3 days.
13. MBIE has limited options to further expand quarantine capacity in Auckland at short notice. In addition to demand from scheduled international arrivals and workforce pressure, hotels are understandably reluctant to agree to shifting from managed isolation to quarantine designation at short notice.
14. Depending on the trajectory of the outbreak, it is likely that there will come a point early next week where MIQ does not have capacity for community positive cases.
15. MBIE are also looking at options to manage arrivals across the border over the coming days if further intervention is required. So far this has included working with the horticulture industry to defer 150 RSE workers that were due to arrive today and temporarily ceasing the release of MIQ vouchers. MBIE will be providing further advice separately on this issue.
16. In the very small numbers of community cases where it may not be deemed safe for a case to enter into MIQF, Medical Officers of Health will identify appropriate quarantine and isolation plans.
17. In preparation for the likely event that MIQ will run out of quarantine capacity, officials are working together to develop a plan for the continued safe management of cases and close contacts, including the role of DHBs and the health system. This will likely need to involve community-based quarantine for at least some community cases.

*Proposed responses:*

18. To provide ongoing clarity and assurance, we propose that you re-confirm the existing quarantine and isolation approach to use managed quarantine facilities for positive community cases.
19. To support this work, agencies will work together on scenario planning to identify potential demands on managed isolation and quarantine and develop effective options to respond.
20. Scenario planning will help identify future capacity constraints, and whether different quarantine and isolation settings are required in the future.

### **Issue 2: What should happen to close contacts – where should they be accommodated and who should provide support?**

*Current context:*

21. Given the scale of the current outbreak, and with the safety measures in place at Alert Level 4, most close contacts of community cases will be safe isolating at home. In some instances, for example where there is overcrowded housing or it involves hostels or university accommodation, isolation away from home may be required. The Ministry of Health manages the health needs of close contacts isolating at home or in the community while their non-health welfare needs are managed by the Care for Community (CSC) programme overseen by the Ministry for Social Development.



22. As at 24 August, there were more than 14,000 close contacts identified in this current outbreak. Only a small proportion of these, a total of 9 people in Auckland, are deemed to be unable to safely isolate in their own homes and are being managed in MIQFs.
23. Given the pressures on managed isolation and quarantine facilities, enabling close contacts to safely isolate at home is the primary response and they are only placed into a facility if there is no other safe, viable alternative. The Holiday Inn Hotel in Auckland (200 rooms) is currently being used as managed isolation facility for close contacts who cannot self-isolate at home and symptomatic border arrivals.
24. The 200 rooms in the Holiday Inn need to remain flexible so that they can be used within the system as required. With the current pressure on managed isolation and quarantine capacity, any free space in the system needs to be utilised appropriately. This may mean that the Holiday Inn is used for a combination of community close contacts, symptomatic border arrivals and other returnees, or it may need to be designated as a dual use isolation and quarantine facility.
25. Depending on the trajectory of the outbreak, there may come a point where MIQ does not have capacity for community close contacts (unless they are going into quarantine facilities with a positive case).
26. DHBs also have a small number of community isolation rooms which could be used but not all DHBs currently have this capacity established. DHB-led services to provide community-based wrap-around options for close contacts with higher health or welfare needs are currently being implemented. These services are funded to manage a limited number of people during small outbreaks. There is currently a small amount of capacity in a limited number of regions, and the wrap-around support services provided by the Ministry of Social Development (MSD) and community agencies are stretched, particularly in Auckland.
27. The experience in New Zealand over the last 18 months has been that compliance with requests for cases and contacts to self-isolate has been very high. Ongoing compliance is dependent on good relationship management and adequately supporting the health, welfare, and cultural needs of those isolating.

*Proposed responses:*

28. To assist MBIE with forward planning and certainty, we propose that up to 100 spaces are reserved (tagged) in Managed Isolation and Quarantine Facilities (MIQF) for close contacts if needed.
29. In preparation for the likely event that MIQF capacity for close contacts will be reached, MBIE and Health officials are working together on plans for alternate arrangements.
30. We are also actively considering how we can continue to strengthen our management and support of close contacts in community isolation and home-based isolation. The ongoing success and safety of this would depend on effective coordination and clear accountabilities, as well as managing equity considerations and being responsive to individual and family needs (e.g cultural or disability related needs).
31. Considerations around quarantine and isolation will need to continue to inform and be informed by decisions around Alert Level changes.

### Issue 3: Ensuring availability and safety of transport options for cases and close contacts required to travel to quarantine and isolation facilities

#### *Current context:*

32. Currently transport for cases and close contacts if required is managed by MBIE between the air border and managed isolation facilities. If there is a need to transport a case within a district, for example home to hospital, DHBs have plans to safely do so working closely with MIQF regional coordinators and private transport providers. Inter-regional travel, which has been coordinated by MBIE working closely with private transport providers (buses and in some cases charter flights), has been arranged on a case-by-case basis which has previously led to delays. In both cases, Medical Officers of Health approve a Transport Plan to ensure transportation is safe and in accordance with infection prevention controls.
33. As 15 out of 20 DHBs do not have MIQFs in their regions, inter-regional travel may be in high demand if there is any spread of COVID-19 to regions without facilities and MIQ-based quarantine or isolation is required. Inter-regional travel can lead to a range of operational challenges, including Medical Officer of Health time in planning, risks of transmission during transport (including for the driver and staff) and logistics of managing vehicles and staff being away from their local Public Health Unit.
34. We have guidance in place to support Medical Officers of Health's role in making appropriate plans for safe transport for individuals and/or their household contacts.

#### *Proposed responses:*

35. To ensure clarity around transport, we propose to re-confirm that DHBs lead coordination for travel within their region and MBIE leads coordination for inter-regional travel for community cases (and in some cases close contacts) if required. Medical Officers of Health would provide relevant support as required, particularly around managing health risks and establishing the safety of the proposed transport. These accountabilities would support the availability, consistency and safety of inter-regional transport options.
36. We will update relevant guidance and send out communications to this effect.

### **Communicating the approach to managing community cases and their close contacts**

37. We will develop communications and update supporting guidance for all relevant stakeholders on the ongoing approach to managing community cases and close contacts. This would include MIQF, Public Health Units, Medical Officers of Health, the Ministry of Social Development and NEMA. We would update other agencies involved in the all of government response.

### **Equity**

38. To maintain the integrity of the quarantine and isolation system, it will be important that equity is considered in ongoing responses. Scenario based planning will consider equity implications, and this will inform the ongoing support services provided.



## Next steps

39. Both ministries will continue to provide advice on settings as the context changes, and if any changes are required as a result of scenario planning.

ENDS.

Released under the Official Information Act 1982

# Briefing

## Risk-based approach to reconnection: proposed health requirements under the three entry pathways

<b>Date due to MO:</b>	27 August 2021	<b>Action required by:</b>	N/A
<b>Security level:</b>	IN CONFIDENCE	<b>Health Report number:</b>	20211933
<b>To:</b>	Hon Chris Hipkins, Minister for COVID-19 Response		

### Contact for telephone discussion

Name	Position	Telephone
<b>Dr Ashley Bloomfield</b>	Director-General of Health	s 9(2)(a)
<b>Maree Roberts</b>	Deputy Director-General, System Strategy and Policy	s 9(2)(a)

### Minister's office to complete:

- |   |                                    |  |
|---|------------------------------------|--|
| <input type="checkbox"/> Approved             | <input type="checkbox"/> Decline   | <input type="checkbox"/> Noted               |
| <input type="checkbox"/> Needs change         | <input type="checkbox"/> Seen      | <input type="checkbox"/> Overtaken by events |
| <input type="checkbox"/> See Minister's Notes | <input type="checkbox"/> Withdrawn |  |

Comment:



# Risk-based approach to reconnection: proposed health requirements under the three entry pathways

---

**Security level:** IN CONFIDENCE      **Date:** 27 August 2021

---

**To:** Hon Chris Hipkins, Minister for COVID-19 Response

---

## Purpose of report

1. This briefing reports back on the development of the three risk-based pathways for entry into New Zealand, with initial advice on who would be able to enter each pathway and the applicable health requirements on travellers.

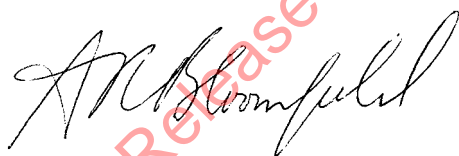
## Summary

2. In August 2021, Cabinet agreed, as part of Government's *Reconnecting New Zealanders* approach, to shift from a country-based approach with two entry pathways (Quarantine-free travel zones and 14-day managed isolation and quarantine) to a risk-based approach with entry pathways for low, medium, and higher-risk travellers [CAB-21-MIN-3505 refers].
3. New Zealand has the opportunity afforded by vaccines to protect the hard-won gains and plan carefully for the phase ahead. In doing so, we need to develop the most effective package of health measures under the three risk pathways that will keep COVID-19 from entering the community.
4. New Zealand depends on its international connections, so pathways to restoring those safely remain a priority. The risk-based pathways framework supports robust criteria to maximise the gains of reconnection by granting streamlined entry to New Zealand, but without causing unacceptable and unmanageable risks to New Zealanders' safety.
5. This framework aims to channel inbound travellers along three pathways and impose health measures that are proportionate to the risk they pose.
6. Factors that will be considered as part of the health settings under the three pathways, will include applicable vaccination testing, isolation, and contact tracing requirements to give confidence that the increased risk of more-porous borders can be managed by border and health systems without leading to undue harm to people's safety.
7. If you agree with the general approach to the proposed health requirements, the Ministry of Health will further refine the health requirements for each of the traveller pathways for your consideration prior to the October 2021 Reconnecting New Zealanders Cabinet Paper.

## Recommendations

We recommend you:

- a) **Note** that in line with Government's commitment to an Elimination Strategy, we need to maintain the most effective set of health measures at the border to keep COVID-19 out of the community **Noted**
- b) **Note** that this report back provides an initial framework that will require further details before the final report back to Cabinet in October 2021 **Noted**
- c) **Note** that the health requirements outlined below will need to flex and adapt as the global and domestic environment evolves **Noted**
- d) **Note** that a country-risk assessment will be a key consideration for traveller risk and the Ministry of Health (the Ministry) is building on an existing country-risk assessment tool to determine a baseline for all countries **Noted**
- e) **Note** that the Ministry is seeking science and technical advice to establish vaccination standards for inbound travellers into New Zealand **Noted**
- f) **Note** that in light of a growing black market for fake vaccination and testing certificates, the Ministry reinforces the need for an internationally recognised, digitally verifiable vaccination certificate **Noted**
- g) **Note** that the Travel Health Declaration system will be a key tool to help operationalise the traveller risk pathways **Noted**
- h) **Note** that options for health requirements on arrival are being refined, including options for health screening, testing and isolation settings **Noted**
- i) **Note** that contact tracing will likely be a requirement for travellers from all three pathways. **Noted**
- j) **Agree** to the broad approach outlined in this paper and direct officials to further refine the health requirements prior to October 2021 Cabinet Paper **Yes/No**



Dr Ashley Bloomfield  
Te Tumu Whakarae mō te Hauora  
**Director-General of Health**  
Date: 27 August 2021

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

# Risk-based approach to reconnection: proposed health requirements under the three entry pathways

## Context

1. In August 2021 Cabinet agreed, as part of Government's Reconnecting New Zealanders approach, to shift from a country-based approach with two entry pathways (quarantine-free travel (QFT) zones and 14-day managed isolation and quarantine (MIQ) requirement) to a risk-based approach with entry pathways for low, medium and higher-risk travellers [CAB-21-MIN-0305].
2. The approach proposed in this paper builds on the protections afforded by vaccines and the hard-won lessons from COVID-19 response to date, to plan carefully for gradual easing of border restrictions and the phased international reconnection. The approach requires the most effective package of health measures under the three risk pathways to keep COVID-19 from entering the community.

## Determining the most effective package of health measures for each pathway

3. The Ministry of Health (the Ministry) has been refining the proposed criteria for the three pathways and has developed initial advice on possible health requirements for travellers, including vaccination, testing and isolation requirements.
4. This briefing presents initial criteria, which will be fleshed out once areas of expertise such as public health who are responding to the August 2021 Delta outbreak have capacity, and we have learned more about the virus from our own experience and internationally. Greater certainty, along with details on the operational implications, will be provided in the report back to Cabinet in October 2021.
5. As we strive to define a core set of health measures that could apply to traveller categories, evidence continues to evolve, while new variants of the virus continue to emerge. This means that we will need to adjust our settings for the three entry pathways from time to time to ensure that we continue to keep New Zealanders safe from COVID-19.

## Entry criteria for the pathways

6. As New Zealand depends on its international connections, developing pathways to restoring those safely remains a priority. However, as border restrictions ease the risk of incursions will increase. Alongside measures to prepare for, stamp out and manage the impact of any resulting outbreaks, reducing the risk at the border is the key means of preventing New Zealand's health system from becoming overwhelmed by the virus. The risk-based pathways framework accordingly supports robust criteria to maximise the

gains of reconnection by granting streamlined entry to New Zealand along carefully managed pathways that do not cause unacceptable risks to New Zealanders' safety.

7. A traveller's vaccination status will become one of the most important considerations in traveller risk, alongside a country-risk assessment. As agreed by Cabinet in the August 2021 report back [CAB-21-MIN-3505 refers], the vaccination standards will apply to low and medium risk travellers. Travellers who are not vaccinated will need to enter via the high-risk pathway. The potential entry criteria is illustrated in **Table 1**.

**Table 1. Potential Entry Criteria for three risk-based pathways**

	<b>Low-risk pathway</b>	<b>Medium-risk pathway</b>	<b>Higher-risk pathway</b>
<i>Vaccination status</i>	Vaccinated with NZ-approved credential	Vaccinated with NZ-approved credential	Not required
<i>Country Risk Rating</i>	Most low-risk countries	Most medium-risk country	High-risk and very high-risk countries
<i>Pre-departure testing</i>	TBC – likely	TBC – likely	As per current settings.

*Country risk assessment*

8. The Ministry has developed a country risk rating framework which currently assesses very high-risk countries only. We are building on the existing framework to create a system that will assess all countries to create a baseline, and a process to keep all countries' status up to date.
9. The risk ratings for countries will be used to inform the entry pathways for individual travellers visiting New Zealand once the phased reopening of the border begin.
10. An interagency group will assess countries and assign HIGH, MEDIUM, or LOW ratings. The criteria is likely to include:
  - a. in-country risk including daily new cases, daily cases per million, trend and deaths per million
  - b. risk to New Zealand's border including incoming arrivals at the New Zealand border, MIQ bookings, and modelling of predicted cases at the border, and
  - c. other relevant domestic considerations including system readiness, international relations, and vaccination rates in New Zealand.
11. This project is in its initial stage of development and the agreed assessment criteria is yet to be finalised. Officials will report back on this in the October 2021 Cabinet paper.

*Vaccination standards for inbound travellers in low and medium-risk pathways*

12. The efficacy of different COVID-19 vaccines currently in use internationally varies. While most vaccines offer protection against severe disease and illness, some do not appear to offer the same level of protection against infection and transmission.

## Document 9

13. The Ministry is working with Medsafe and the COVID-19 Vaccine Science and Technical Advisory Group (CV-TAG) to establish vaccine standards for inbound travellers.
14. Preliminary advice from the CV-TAG is that the Ministry should consider recognising vaccines approved by regulators in countries with similar regulatory systems to New Zealand. These systems have similarly robust approval processes and conduct thorough assessments of applications of new medicines.
15. Further advice from CV-TAG will also include factors such as number of doses, dose intervals, mixed dosing, and time since last dose that will be required as part of the standard. The expected timeframes for advice and decisions are end of September, and the final input will be provided to Cabinet in October.

### *Vaccination certification requirements for low- and medium-risk pathways*

16. At present there are numerous types of vaccination certificates being issued internationally. There is also a growing black market of fake certificates. Until the proof of vaccination becomes more standardised with agreed security features, this variability will present challenges for accepting and verifying COVID-19 health credentials of international travellers.
17. The rigor around what New Zealand would accept as a valid proof of vaccination needs to reflect the Government's foremost priority to use the border as its key line of defence to keep COVID-19 out of the New Zealand community.
18. The Ministry's initial thinking is that, for certain inbound travellers to qualify for no quarantine upon entry to New Zealand, we would need to have extremely high confidence in the authenticity of their certificates presented on arrival. The highest level of confidence would be provided by the certificates being aligned to one of the international standards, with inbuilt security features that protect against falsification, and are able to be verified digitally.
19. The Ministry will continue work through the process of defining what the requirements for proof of vaccination might be, and what additional mitigations might be required.
20. The Ministry continues to work with New Zealand Customs, Immigration New Zealand and other agencies on the Travel Health Declaration system to ensure COVID-19 vaccination credentials can be assessed and verified for inbound travellers under the new risk-based approach.

### *Pre-departure testing requirements for travellers*

21. Currently, there is mixed, inconclusive evidence on the effectiveness of pre-departure testing (PDT) in reducing the risk of new cases entering New Zealand. However, it is still a key layer of our protection. The Ministry considers that PDT will likely be required for low and medium-risk pathways. This will ensure that, at least in the initial stages of reopening, we can gain confidence in the traveller pathways and functioning of our systems.
22. It is also expected that travellers in the higher-risk pathway will continue with the current settings in place for PDT requirements for high and very-high risk countries. Advice on PDT for all pathways will be finalised ahead of the October 2021 Cabinet Paper.

## **Travel Health Declaration will be used to verify health information prior to travel**

23. Implementing the risk-based three entry pathway into New Zealand requires the health status of individuals to be checked before boarding the craft and for their health status credentials to be verified and checked on arrival
24. The traveller health declaration system will enable all inbound passengers to make a health declaration (eg, vaccination certification and PDT), ensuring the declarations are verifiable and strongly bound to the passenger, and can be individually risk assessed prior to travel.
25. It will ensure that passengers are directed to the correct testing and isolation requirements based on their assessed risk, and will underpin the scaled re-opening of the border, in a safe way

## **Health requirements for traveller pathways upon arrival to New Zealand**

26. Assessing a range of health requirements on arrival will be an important part of our border protections, in the same way that we have biosecurity and customs checks. A range of potential checks can be applied differentially for different categories of travellers. These requirements, on top of differentiating among the sources and routes of inbound travellers, would further reduce the risks they might pose once they have entered the country. The measures could flex depending on the level of risk and could loosen over time as we gain assurance that we can safely manage volumes.

### *Symptom screening*

27. At present, health screening at the border is limited to self-declared symptoms, with referrals to healthcare professionals at the border to determine appropriate management. As global movement increases, respiratory infections with similar symptoms to COVID-19, such as common colds and seasonal influenza, are likely to increase, and to present more-frequently at our border.
28. Border health screening for a significant number of arrivals will require adaptation of health structures and resourcing at the border. Investment in airport infrastructure may also be required to enable travellers to wait for border screening and move through airports in ways that would not increase the risk of COVID-19 transmission as volumes of travellers increase. Further work is required by health and border officials to determine the possible approaches, the investment needed, the lead-in time, and feasibility of border health-screening on a large scale.

### *Temperature screening*

29. There is some doubt about the efficacy of temperature checking using body scanners as there is evidence of high rate of false positives. The Ministry will report back with a fuller review of the efficacy of temperature screening ahead of the October 2021 Cabinet Paper.

### *Arrival testing requirements*

30. Arrival testing may be applied to all pathways to facilitate the safer entry of vaccinated travellers. However, the Ministry's view is that point of arrival testing will most likely be relevant for medium-risk travellers, pending further exploration and the emergence of new technologies.
31. There are two different testing options which could be deployed as point of arrival testing: rapid antigen testing administered by a trained healthcare worker; and rapid reverse transcription polymerase chain reaction (RT-PCR) testing. It is expected that RT-PCR would provide much more-reliable results, although it would take more time and investment to establish as a high throughput testing method [HR20211972 refers].
32. A pilot looking at the various options for testing at the border and how to implement these effectively is currently being designed. This will provide more information which, along with public health input, will be inform the Ministry's final advice on arrival testing requirements.

### *Isolation requirements*

33. Vaccinated travellers from low-risk countries will not be required to enter a MIQ facility on arrival, whereas the current 14-day MIQ requirement will continue for travellers coming through higher-risk pathway. For the medium-risk pathway travellers, short-stay MIQ or home-based isolation options are being considered as the main isolation requirement.
34. MIQ has a strong track record of risk reduction and this continues to be refined with experience. However, short-stay MIQ would require significant investment in workforce and financial resources and would strain already-stretched workforces. This may not be proportionate to the level of risk to the community once we have achieved significantly high vaccination uptake.
35. Home isolation may be another option, but while it may not pose the same capacity and resource constraints as MIQ, there is a high level of uncertainty about people's behaviour and their likely adherence to home isolation requirements. There is a spectrum of options for home-based isolation depending on the risk-level of travellers this option is used for (if any). A pilot currently planned for later in the year will test the logistics around a more stringent home isolation option.

### *Contact tracing*

36. Contact tracing will be a key requirement for travellers in all three pathways.
37. Nau Mai Rā has been created as a secure data collection point to request information from travellers coming through current QFTZ areas. It can be expanded and required for contact tracing before passengers arrive in New Zealand, so that contact tracers can efficiently use these details to contact travellers in the event of a COVID-19 outbreak in the area from which they have arrived from.
38. Officials are exploring technology solutions to support larger scale contact tracing, which may help to address some of the capacity constraints evident in the current outbreak.

## Other key considerations for the traveller pathways

39. The following considerations are still being explored and will be reported back in the October 2021 Cabinet paper.

### *Unvaccinated children*

40. A particular challenge with the pathway model is groups of mixed-risk travellers, for example families with unvaccinated children. Further public health advice is needed to determine what proportionate measures can be used to mitigate potential risk posed by unvaccinated children. This also raises equity concerns and issues relating to the New Zealand Bill of Rights Act (1990).

### *Transit route*

41. The risk in transit is complex depending on the route travelled prior to, and during, the flight itinerary. Some evidence suggests that cases of in-flight transmission have been too rare to attribute risk to airlines or transit airports, but there are cases of people contracting COVID-19 in-flight, including the recent case of an Air New Zealand aircrew member arriving from Japan. Further work is required to assess transit route risk, the country-risk, the operational parameters of the transit hubs, and in-flight transmission.

## Equity

42. As this approach creates restrictions which are specifically tailored to the severity and nature of the public health risk presented by different travellers, these restrictions will be more proportionate and provide a more balanced and equitable approach.
43. However, there are equity concerns particularly around our vaccination requirements, as vaccine availability varies significantly between countries and will not be available for certain groups eg children.
44. An in-depth equity analysis will be conducted as part of the report back to Cabinet in October 2021.

## Next steps

45. If you agree to the broad approach outlined in this report, the Ministry will work to further refine the health settings across the three risk-based pathways and report back on these to Cabinet in October 2021.
46. The Ministry of Health will also work with the Department of Prime Minister and Cabinet and border agencies to report back on how these settings may be operationalised, including developing the legal framework for transitioning from our existing border settings.
47. The Ministry will take further steps to test the approach, including through conducting pilots on rapid antigen testing.

ENDS.