~~[SENSITIVE]~~

DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Briefing: Review of New Zealand's COVID-19 Protection Framework and self-isolation settings: 19 May 2022

Date:	19 May 2022	**Report No:**	DPMC-2021/22-2137
		Security Level:	~~[SENSITIVE]~~
		Priority level	[Priority]

	Action sought	**Deadline**
Rt Hon Jacinda Ardern **Prime Minister** Hon Grant Robertson **Deputy Prime Minister** Hon Kelvin Davis **Minister for Māori Crown Relations: Te Arawhiti** Hon Chris Hipkins **Minister for COVID-19 Response** Hon Carmel Sepuloni **Minister for Social Development and Employment** Hon Andrew Little **Minister of Health** Hon Kris Faafoi **Minister of Justice** Hon Dr Ayesha Verrall **Associate Minister for COVID-19 Response**	**agree/disagree** to recs	18/05/2022

Name	**Position**	**Telephone**
Alice Hume	Head of Strategy and Policy	s9(2)(a)
Anna Ferguson	Policy Advisor	

Minister's Office

Status:

☐ Signed ☐ Withdrawn

~~[SENSITIVE]~~

Comment for agency

Attachments: Yes

Briefing

Review of New Zealand's COVID-19 Protection Framework and self-isolation settings: 19 May 2022

To:	COVID-19 Ministers		
Date	19/05/2022	**Security Level**	[SENSITIVE]

Purpose

1. This briefing recommends, based on public health advice and consideration of non-health factors, that all New Zealand remains at the Orange COVID-19 Protection Framework (the Framework) setting, with a further review in a month's time. It also recommends that the self-isolation periods for cases and their household contacts remain at seven days, with a further review to occur with the next colour review.

Executive Summary

2. Case numbers peaked in March 2022, with a steady decline that continued to the week of 17 April 2022. Since then daily case numbers have plateaued nationally, with the Northern Region beginning to see a gradual increase. Hospitalisations rates have slightly increased over the past month and the death rates remain reasonably steady at around nine to 13 average deaths a day (Attachment A provides a full situation update). Reviews of both the self-isolation period for cases and contacts, and the appropriate Framework colour setting were made taking into account this context.

3. Officials support the maintenance of the current seven-day self-isolation periods for cases and household contacts at this time. Modelling has shown that shorter isolation periods, even with 'Test to Release' type requirements, could increase hospitalisations in the short term, to a greater or lesser extent, depending on the approach taken. This risks increasing the burden COVID-19 places on the healthcare system over the winter period when it is already under increased pressure, further impacting vulnerable communities, and increasing the number of people unable to work in the short-term due to becoming COVID-19 cases. A short-term, steeper peak in COVID-19 cases could also significantly impact businesses (i.e. from staff illness and reduced turnover due to lower patronage).

4. However, there is a modelled economic impact at current isolation settings of about $188.3 million per month. Further public health and economic modelling will be undertaken over the next few weeks to consider whether that economic impact can be reduced without associated moderate or large increases in hospitalisations. This work will be complemented by consideration of whether public communications and guidance can be strengthened to further mitigate transmission risk associated with any loosening of self-isolation settings. Work will also be done to ensure any future changes to self-isolation periods can be operationalised with a short lead in time.

5. On 16 May 2022, the Ministry of Health's COVID-19 Assessment Committee (the Committee) conducted a review of the Framework colour settings across New Zealand, to ensure proportionality of public health measures and the restrictions on freedoms, relative to COVID-19 risk.
6. Based on the significant ongoing case transmission in the community, low utilisation of antivirals, low booster coverage and the health system still being under pressure, the Committee recommends that all of New Zealand remain at Orange. The Committee also recommends that the Framework setting and isolation and quarantine periods next be reviewed in June.
7. Remaining at Orange is supported by an analysis of the non-health factors that must be considered by Ministers when making decisions on the colour setting: impacts on at-risk populations and iwi Māori, economic impacts, public attitudes and compliance, and operational considerations. Remaining at Orange will allow for economic activity to occur largely as normal, while including some protection against the spread of COVID-19 through the use of facemasks.
8. Self-isolation settings and the Framework colour setting will be reviewed together next month to ensure they are jointly calibrated to be proportionate and minimise the negative impacts of public health measures on people and the economy. If, for example, action is needed to reduce hospitalisations in June, then a range of options could be considered including changes to the Orange setting or moving to the Red setting, alongside the self-isolation settings.

Recommendations

We recommend you:

1. **note** that daily cases numbers are plateauing nationally but are beginning to increase in the Northern Region (infection levels are likely to be higher than the self-reported cases indicate with no decrease in wastewater detection levels since early April 2022)
2. **note** hospitalisation rates have slightly increased over the past month and the death rates remain reasonably steady at around 9 to 13 average deaths a day
3. **agree** to retain the current seven-day isolation period for cases and household contacts

   YES / NO
4. **note** that the Director-General of Health's advice is that:
   - 4.1 All parts of New Zealand remain at Orange
   - 4.2 The isolation period for cases and household contacts remain at seven days
5. **agree**, after consideration of both the Director General's advice and non-health factors, to keep all of New Zealand at the Orange level of the COVID-19 Protection Framework

   YES / NO
6. **note** that the public health assessment committee will meet 15 June 2022 to provide their advice ahead of the next colour setting review

7. **agree** that the next colour setting review will occur during the week of 20 June 2022, or sooner should it be required (for example, due to concerning increases in cases or hospitalisations)

YES / NO

8. **agree** that the next review of the colour setting and isolation periods occur in tandem during the week of 20 June 2022

YES / NO

9. **agree** that before the next review, agencies led by the Ministry of Health work together to ensure that any changes to self-isolation settings can be implemented shortly after a decision in June, should Ministers decide to change those settings

See my comment on analysis required wrt Table 1.

YES / NO

10. **agree** that the Minister for COVID-19 Response announces Ministers' decisions

YES / NO

11. **agree** to proactively release this report, subject to any appropriate withholding of information that would be justified under the Official Information Act 1982.

YES / NO

Alice Hume **Head of Strategy and Policy, COVID-19 Group**	Rt Hon Jacinda Ardern **Prime Minister**
19/05/2022	...../...../2022

Hon Grant Robertson
Deputy Prime Minister

...../...../2022

Hon Kelvin Davis
Minister for Māori Crown Relations: Te Arawhiti

...../...../2022

Hon Chris Hipkins
Minister for COVID-19 Response

...../...../2022

Hon Carmel Sepuloni
Minister for Social Development and Employment

...../...../2022

Hon Andrew Little
Minister of Health

...../...../2022

Hon Kris Faafoi
Minister of Justice

...../...../2022

Hon Dr Ayesha Verrall
Associate Minister for COVID-19 Response

22/5/2022

Review of self-isolation periods

9. The Ministry of Health (MoH) has conducted a review of the self-isolation requirements on both cases and their household contacts. The review considered, as outlined in Attachment B, options to keep the current 7-day self-isolation requirements or reducing the requirements to 5 days[1] (see Attachment B for the modelling analysis). As a high number of cases are still infectious at day 5, the modelling includes consideration of a 'test to release' requirement for cases to leave isolation (i.e., requiring cases to return a negative RAT before they may leave isolation).

10. This review concluded that the existing legal requirements for the current 7-day self-isolation periods are still proportionate and balanced from a public health perspective.

11. Officials support the maintenance of the current 7-day self-isolation periods at this time, as a reduction to 5 days, could increase the number of infections and put extra pressure on the health system in the two to seven weeks after the change.

12. Models predict that changing the current settings to five days isolation for cases then 'Test to Release' and five days self-isolation for household contacts with current testing requirements[2] would increase hospitalisations by one to 17 percent in the short-term. It could also further impact upon vulnerable communities and increase the number of people unable to work in the short-term due to becoming COVID-19 cases.

13. Modelling estimates suggest that the economic impact of the current isolation settings is about $188.3 million per month. Further public health and economic modelling will be undertaken over the next few weeks to investigate potential other options that would reduce this economic impact without giving rise to disproportionate increases in hospitalisations. This work will be complemented by further consideration of whether public communications and guidance can be strengthened – as ensuring compliance with requirements, particularly if the requirements are comparatively reduced or made more complex by introducing 'test to release' for cases, will be critical to mitigating the increases in transmission risk associated with any loosening of isolation and quarantine settings.

14. By maintaining the current self-isolation periods for now we will comparatively reduce the burden COVID-19 places on the healthcare system over the winter period, reduce the impact on vulnerable communities, and avoid a short-term, steeper peak in COVID-19 cases impacting businesses (i.e. from staff illness and reduced turnover due to lower patronage). These reasons are expanded on further below.

Impact on the health and disability system

15. MoH anticipates that in the short term, the health system will need to manage a significant burden of disease due to COVID-19 and an anticipated increase in influenza-like illnesses during winter, along with increased prevalence of other illnesses (such as RSV and measles) associated with re-opening the borders. Should isolation periods be reduced, or removed entirely for household contacts, the winter period could see an increased incidence of COVID-19 and related hospitalisations, putting further pressure on the health and disability system. This is particularly pertinent if it were to result in increased numbers of cases in healthcare workers, further reducing the health system capacity.

Impact upon vulnerable communities

[1] The Centre for Disease Control and Prevention in the United States has reduced the isolation period for cases to 5 days and the United Kingdom also recommends 5 days self-isolation after a positive test.

[2] On days 3, 5 and if symptomatic

16. Māori, Pacific, disabled and older people have been most impacted by COVID-19 to date. Māori and Pacific peoples continue to be disproportionately affected in terms of both the risk of cases being hospitalised and the population case rate, and will be disproportionately affected by any reduction in isolation and quarantine periods as transmission is increased; especially as there remains disparity in immunisation coverage in these communities.

17. The impact on vulnerable communities will be further compounded by winter illnesses, the increased mixing of people within the community at Orange and more people travelling to New Zealand now the borders are open are all likely to result in an increase in daily cases and hospitalisations in coming months and place strain on the health system. It is therefore the view of MoH and DPMC to maintain the current isolation periods as a protective measure against transmission in vulnerable communities at this time.

18. Maintaining the current isolation settings at this time will help to prevent existing inequities within the health system – noted in the Waitangi Tribunal's Haumaru report and by the Disability Commissioner – from being further exacerbated.

Economic impacts

19. The number of people required to isolate at any one time has a significant economic impact due to people being too unwell or unable to work from home, reducing the number of hours worked across the population.

20. The Treasury's estimate of the economic impacts of the 7-day self-isolation for both cases and their household contacts is $188.3 million a month. Moving to a 5-day self-isolation period for cases with a 'Test to Release' requirement, and a 5-day self-isolation period for household contacts reduces the economic impact by $20 million a month. The economic impact of only requiring cases to isolate (5-day self-isolation period for cases with a 'Test to Release' requirement) is $114 million a month. As such Treasury's preferred option would be to move to a 5-day self-isolation period for cases with a 'Test to Release' requirement, with no isolation requirement for household contacts.

21. However, removing isolation requirements may have a smaller impact on people's ability to work than this modelling suggests. While people will be able to leave isolation, they may still be unwell, looking after unwell whānau or taking care of dependents, affecting their ability to work and resulting in a smaller reduction in economic costs.

Table 1: Estimated number of isolation days in May against self-isolation options

Policy setting, including testing for household contacts Day 3, 5 or 7 and if symptoms - for each option	Case isolation days per month (change from current settings)	Contact isolation days per month (change from current settings)	Total isolation days per month (change from current settings)
Baseline: • 7 days isolation for cases. • 7 days isolation for household contacts	1,211,000	1,233,840	2,444,840

Not clear if this analysis (Table 1) factors increased cases that would result from this policy. This should be ~~stated~~ included if this data is to presented in future briefings.

• 5 days isolation for cases, 1 test to release. • 5 days isolation for household contacts	1,103,200[3] (reduced by 107,800 or 8.9%)	1,070,400 (reduced 163,440 or 15%)	2,173,600 (reduced by 271,240 or 11%)
• 5 days isolation for cases, 1 test to release. • No quarantine for asymptomatic household contacts but strong precautions	1,288,000 (increased by 77,000 or 6.6%)	71,284[4] (reduced by 1,162,556 or 94%)	1,359,284 (reduced by 1,085,556 or 44%)

Public health risk assessment of colour setting

22. On 16 May 2022, the Ministry of Health's COVID-19 Assessment Committee (the Committee) conducted a review (Attachment C) of the Framework colour settings across New Zealand, to ensure proportionality of public health measures and the restrictions on freedoms, relative to COVID-19 risk. The Committee considered its advice on the colour setting in the context of the MoH's advice to maintain current isolation periods for cases and household contacts at 7-days noted above.

23. The assessment involved a comprehensive analysis and discussion of the COVID-19 outbreak and health system capacity and demand for services across New Zealand.

24. Based on the available information, the Committee recommends that:

    a. All parts of New Zealand remain at the Orange setting of the Framework; and

    b. That Framework settings and isolation and quarantine periods next be reviewed in early-June.

25. The Committee applied health factors recently agreed to by Cabinet [CAB-22-MIN-0114], to determine its advice related to the colour settings, namely:

    a. degree of protection from severe health outcomes due to COVID-19, gauged by vaccination coverage and immunity levels among the general population and vulnerable populations, and availability of treatments (e.g. antivirals) to reduce the severity of illness from COVID-19; and

    b. capacity of the health system to meet demand due to COVID-19, given competing demands from other illnesses (including seasonal and imported conditions), backlog of prevention activities and the care of people with long term conditions.

Degree of protection

26. The Committee noted that the trajectory of cases was that the overall decline in cases has slowed, with many regions showing a plateau or even a slight increase in transmission.

27. This significant ongoing case transmission in the community (as seen in the border worker testing and wastewater results), provides the context in which to view the likely waning levels of immunity of the population (as the period post most vaccinations or

[3] While this option could result in 14% more cases, cases will likely spend an average of 5.6 days in isolation compared to 7 days, resulting in an overall reduction in days isolating.

[4] Despite not having a legal obligation to self-isolate in this scenario this figure captures the number of household contacts each month that are likely to isolate after becoming symptomatic but before testing positive

infections grows longer), as well as the slow uptake of booster vaccinations generally and for vulnerable populations in particular. The increase in case rates for vulnerable populations was also noted with concern, given the relatively low uptake of antivirals.

28. Since the introduction of the Paxlovid and Molnupirvair antivirals, there has been a relatively low utilisation, with 1970 and 143 courses being prescribed respectively. This could be due to a number of factors including health practitioners being unfamiliar with the medications, the medications not being clinically appropriate for individual patients despite otherwise being eligible, or Pharmac's access criteria continuing to be too restrictive.

29. To address the latter point the MoH meets twice weekly with Pharmac to discuss the criteria for oral COVID-19 therapeutics – with the most recent expanded criteria coming into effect from 5 May. Although it is too soon to analyse the impact of these changes, the MoH continues to work closely with Pharmac to monitor utilisation against supply, and to review the access criteria to ensure that those that would benefit from the medication can do so. It is possible to adjust the access criteria if necessary. Pharmac has also introduced an online tool to allow prescribers to determine more easily if their patient is eligible.

30. The Committee also noted the reporting of cases of subvariants detected at the border, and the reclassification by the European Centre for Disease Prevention and Control of subvariants BA.4 and BA.5 as variants of concern.

31. Booster uptake for Māori and Pacific People aged 65 and over is around 87 percent and 81 percent respectively. However, booster rates are substantially lower for the total eligible Māori population. Booster uptake rates are not keeping pace with eligibility, which will be in part due to those who have recently had COVID-19 being required to wait three months before they receive their next dose. There is a risk of increased hospitalisation amongst vulnerable groups, particularly Māori and Pacific People, due to increasing transmission in these groups, together with slower booster uptake and waning immunity.

Capacity of the health system to meet demand for COVID-19

32. Pressure on the health system continues with only the Waikato District Health Board reporting a return to full levels of planned care, though there is a considerable backlog across many services. All others report ongoing pressure. Workforce remains an area of concern exacerbated by COVID-19, including due to isolation and quarantine requirements of staff, however it's noted that there are high rates of vaccination across the health workforce. Health system pressure is likely to remain in the context of the winter season and anticipated waning immunity and/or new variants seeing a second COVID-19 wave that could exacerbate demand for primary and secondary health services.

33. It also noted that there is increasing rates of hospitalisation, which may increase further in the future due to slow booster uptake and risks to vulnerable groups. The average age of those currently hospitalised in the Northern region has remained stable at 59 from 1 May to 8 May. Average length of stay in hospitals as of April 2022 was estimated to be 3.1 days but this will likely increase with increasing infections in those aged 45 and over.

Assessment of proposal to remain in Orange against non-health factors

Colour setting proposal

34. Officials propose Ministers agree to keep all of New Zealand at Orange. Staying at Orange is supported by an assessment of the health factors above and the non-health factors set out below for moving between colours in the Framework.

35. The following section assesses the proposal against the non-health factors agreed by Cabinet:
    - Impacts on at-risk populations and iwi Māori
    - Economic impacts
    - Public attitudes and compliance
    - Operational considerations

Impacts on at-risk populations and iwi Māori

36. Vulnerable groups have been disproportionately affected by COVID-19. This trend is continuing with Māori, Pacific people, those living in deprivation, with disabilities and/or co-morbidities, and older people in some instances experiencing disproportionate rates of the virus and suffering more significantly from its effects. Agency feedback has been supportive of retaining the current Orange setting for the whole of New Zealand with communities having identified that it allows for economic activity to occur largely as normal, while including some protection against the spread of COVID-19 through the use of facemasks.

37. Iwi Māori have consistently advocated for a conservative approach to be taken to manage the impact of COVID-19 on Māori communities who are more likely to experience negative outcomes. The level of support available to whānau in rural and isolated communities who become unwell remains a concern, as does the impact of the COVID-19 on the ability of the health system to provide care for other health conditions.

38. Te Puni Kōkiri (TPK) supports the proposal in this paper. However they, and Te Arawhiti, remain concerned about the vulnerability of some Māori due to:

    - continued high levels of infections in the community with Māori still experiencing disproportionate impacts
    - continued low levels of vaccination for some cohorts in the Māori population and for some communities
    - the uncertain impacts of the opening of borders and the possibilities of new variants of COVID in the community
    - the compounding impact of COVID-19 and the onset of winter and associated risks from cold homes, winter illnesses such as colds and flu, and additional medical conditions that are likely to impact on Māori, particularly tamariki, such as rheumatic fever and RSV.

39. The Office of Disability Issues (ODI) anticipates that the disability community would support remaining at the Orange setting (as opposed to a shift to Green, which would be likely to increase anxiety). Some community members will prefer the Red setting due to the additional protective measures this colour setting provides. The community has told ODI that the lessening of restrictions has generated some concerns about safety. This unsafe feeling impacts behaviours and overall wellbeing. However, the continued use of face masks, particularly when accessing essential services, creates reassurance to help mitigate against these concerns. Further detail regarding the impacts of COVID-19 on the Disability community can be found in Attachment D.

40. The Ministry for Pacific Peoples' ongoing engagements with Pacific communities confirm that the Omicron outbreak continues to impact the social and economic wellbeing of some Pacific families. Pacific peoples have high rates of comorbidity, putting them more at risk of respiratory diseases, including COVID-19 and seasonal influenza. Through its Pacific Aotearoa Community Outreach, work continues to support and encourage harder-to-reach Pacific peoples to get vaccinated. As the winter months approach, this includes the booster vaccination, flu vaccination and supporting parents/guardians of children aged 5-11 years old who have not received the paediatric vaccine.

41. The Ministry for Ethnic Communities continues to be concerned that the Orange setting does not provide effective protection for immuno-compromised and older people. However, Orange has enabled better economic outcomes for ethnic people and their whānau, who are more likely to be in insecure work within industries impacted by higher levels of restriction. The increase in activity since the move to Orange has improved patronage for ethnic businesses and places of worship. This has improved the sense of social inclusion and generated more revenue for these communities, which in turn has allowed places of worship to increase their social services they provide and investments back into the community.

42. Whilst most older people are adapting to life under the Orange setting in the Framework further emphasis on how all New Zealanders, can continue to keep themselves safe would be of benefit to older people.

43. As part of its preparation for winter, including to reduce COVID-19 related harms, the MoH is working to identify ways in which vulnerable population groups can be supported to feel better able to participate more fully in community life. As part of this work the MoH has recommended that Level 2 ear loop medical masks be made to clinically vulnerable people and priority populations, at an estimated cost of $18.8 million through to 30 September 2022. P2/N95 particulate respirators are being supplied to health providers from existing MoH stock for use by the most clinically vulnerable patients. Efficacy, wearability, and cost effectiveness were considered in forming the recommendation that Level 2 ear loop medical masks were made available for clinical vulnerable people to use.

Economic impacts from the Framework

44. New Zealand remaining at Orange is estimated to result in a $105 million loss in GDP per week, while a move back to Red would increase the economic impact by $35 million a week. Table 1 shows the anticipated economic impact of the Framework relative to forecasted activity with no public health restrictions. These are estimates, and the Treasury will continue to refine them as new data becomes available.

Table 2: Estimated loss in GDP activity (relative to no restrictions) and assuming open border

	$ million per week	% of GDP
All New Zealand Red	$140	2%-3%
All New Zealand Orange	$105	1%-2%

45. Under the Framework, most businesses are expected to operate relatively normally. The reduction in GDP is primarily driven by distancing requirements, capacity constraints at Red, and the behavioural response of consumers.

46. While the economic impacts of the Framework restrictions are significant, the Treasury considers that the most significant economic impact of the Omicron outbreak is staff having to isolate as a result of becoming unwell or as household contacts, regardless of the Framework level.

Public attitudes and compliance

47. Agencies and Regional Leadership Groups (RLGs) have noted that, anecdotally, face mask compliance is waning. Face mask use is one of the key measures to mitigate the spread of COVID-19 within the community at Orange. To address the risk of increased community transmission due to decreased face mask use, DPMC is implementing a two-stage face

mask campaign. An informational campaign to increase awareness of where face masks are required to be worn at Orange. This campaign is currently live on social media, radio, and billboards in the community. June will see the launch of a motivational campaign to encourage the use of face masks. This campaign will focus on the value of wearing face masks and reinforce their utility in all colour settings.

48. This campaign will likely serve to provide additional protection for vulnerable people, including older people and the disability community, who are currently less confident in being active in the community when face mask use is lower.

Operational considerations

49. The move to Orange has not given rise to any significant adverse impacts on the Care in the Community welfare response or access to the COVID-19 Leave Schemes. However, if there were to be an increase in transmission, this may place additional pressure on community providers supporting people to isolate safely at home.

50. Access to support through the Care in the Community welfare response continues to be either on the phone or people can apply online. In instances where supports cannot be met over the phone or online, general support through the Ministry of Social Development's (MSD's) Work and Income service centres continues to be available in person with differing capacity limits on indoor facilities depending on the Framework settings. MSD has updated their Health and Safety procedures to ensure staff and people seeking support are safe.

51. Feedback from the Regional Leadership Groups (RLGs) suggests that while there is a sense of 'COVID fatigue' within the regions, remaining in Orange is widely considered to be the appropriate approach at this time. Orange allows for the public health protections to remain in place while continuing to enable businesses to operate safely and with certainty. The RLGs noted that, as COVID-19 is still circulating at higher than anticipated levels in the community, it is important to protect vulnerable members of the community, especially given winter is likely to see an increase in other illnesses circulating. Orange is seen to strike a balance between satisfying those with a lower risk appetite by not relaxing requirements, and not be perceived by many as being overly restrictive in the near/foreseeable future.

Financial implications

52. Various schemes available to support individuals and businesses have had high uptake throughout the Omicron outbreak.

Table 3: Uptake of business and individual support

Scheme	Amount appropriated	Paid out
COVID Support Payment	$1.530 billion (for 2021/22)	$1.287 billion (as of 6 May)
Short-term Absence Payment	$710.795 million (for 2021/22)	$26.9 million (10 Dec – 11 May inclusive)
Leave Support Scheme		$333.3 million (10 Dec – 11 May inclusive)

Small Business Cashflow Scheme	$1.414 billion (for 2021/22)	$473.79 million loans approved for 2021/22 (as of 10 May)
Care in the Community and related programmes	Approximately $1.201 billion across Votes Social Development, Māori Development, Pacific Peoples and Education (some allocated prior to the COVID-19 Protection Framework)	

Human Rights (legally privileged)

s9(2)(h)

s9(2)(h)

Te Tiriti o Waitangi Analysis

63. The Crown's obligations to Māori under the Treaty of Waitangi require active protection of tāonga, and a commitment to partnership that includes good faith engagement with, and appropriate knowledge of the views of iwi and Māori communities. In the context of the Framework, this involves considering what will support a national response that is co-ordinated, orderly, and proportionate, considering the Crown's obligation to actively protect Māori health, interests and rangatiratanga.

64. The outbreak has so far had a disproportionate impact on Māori. However, we are currently seeing a lower incidence of COVID-19 among the Māori population than at the time of the last review. The proportion of Māori being identified as new cases has dropped to 11 percent of cases identified in the week to 11 May, as opposed to 18 percent in the week to 12 April. Fatalities have also reduced with Māori making up 7.4 percent of fatalities in the first week of May, down from 12.9 percent in the first week of April.

65. Māori vaccination and booster rates remain lower than the rest of the population (with 56.2 percent of eligible Māori having received a booster dose, versus 72.6 percent of the wider population) largely due to a slower rollout of the initial vaccination campaign to Māori communities. While in the week to 3 May 1,900 Māori received a vaccination dose, trending up for the third consecutive week, first dose vaccinations for tamariki Māori aged between 5 and 11 are under 1,000 for the seventh consecutive week. This has been exacerbated by the high numbers of Māori recently infected with COVID-19 and the three-month interval between becoming a case and receiving a booster dose.

66. Locally-led responses continue to be relied upon particularly in Māori communities where local Māori providers and providers contracted by Whānau Ora commissioning agencies are

mobilising to respond to the demands of their communities. The Māori Communities COVID-19 Fund (MCCF) was established to support Māori, iwi and community providers to accelerate current responses and to build resilience in light of the COVID-19 Protection Framework, in the period to the end of June 2022. It has supported a number of community-led responses aimed at embedding COVID-19 resilience, such as the following Taranaki examples.

a. Ngā Iwi o Taranaki Collective, a community-based health and social services provider in Taranaki, supported to help boost vaccination rates. The Collective has trained a number of iwi members as vaccinators and testers; established a network to supply hygiene packs to whānau; and worked with iwi to increase their response to their communities.

b. The Mahitahi Trust, a kaupapa Māori mental health and addictions service, which has been enabled by the MCCF to address urgent unmet needs that have escalated for whānau affected by COVID-19. Whānau are provided with COVID-19 isolation care bags for those who have tested positive and are therefore isolating including those who are a contact in isolation.

67. Māori provider concern is however increasingly more about the wider socioeconomic impacts of the pandemic on whānau, and in 'catching up' on health services (like broader immunisations for the flu, childhood MMR, screening services) that have been deferred.

68. The health system continues to be unable to provide the usual level of care due to the pressures of managing COVID-19. The impact of this will be experienced more profoundly by Māori who are more likely to have co-morbidities that require ongoing care than the wider population. The delay to planned care will also exacerbate existing inequities in which Māori are diagnosed later, and with more progressed conditions, than Pākehā.

69. Remaining at Orange will allow key cultural activities, such as tangihanga, weddings, and other milestone events to go ahead with minimal restrictions.

70. Maintaining the current settings will provide certainty to Māori enterprise regarding the tools they are able to utilise for safer working environments. It will also serve to temper some of the uncertainty that the pandemic has bought and the impacts this has had on wellbeing.

71. Many Māori enterprises are vulnerable, particularly in industries like tourism, hospitality, services, food production and construction. The Māori economy will be further challenged by the ongoing and changeable aspects of the pandemic and its after-effects, including rising inflation, talent gaps, challenges in securing forward business and issues with navigating a fragmented, disconnected business support ecosystem.

72. Ensuring Māori whānau have comprehensive and immediate supports through the Omicron outbreak will contribute to their resilience so they can leverage recovery opportunities.

Consultation

73. This paper was prepared by the COVID-19 Group within DPMC. The Ministry of Health reviewed the paper and provided specific input and text, including advice on the course of the outbreak, the public health response, and the views and recommendations of the Director-General of Health. The Crown Law Office advised on New Zealand Bill of Rights Act implications.

74. The Treasury, Ministry of Ethnic Communities, Ministry for Pacific Peoples, Te Puni Kōkiri, Ministry of Social Development, Te Arawhiti, and the Office for Disability Issues were

consulted on the paper. Regional Leadership Groups provided feedback regarding the considerations for remaining within the Orange setting and the impacts of self-isolation.

Next steps

75. We recommend that the decision to keep all New Zealand at Orange be communicated as soon as possible. We also suggest announcing when the next review of colour settings will occur, which is proposed for the week of 20 June.

76. The public health assessment committee will meet again on 15 June 2022 to provide their advice ahead of the week of 20 June. Self-isolation settings and the Framework colour setting will be reviewed together next month to ensure they are jointly calibrated to be proportionate and minimise the negative impacts of public health measures on people and the economy. If, for example, action is needed to reduce hospitalisations in June, then a range of options could be considered including changes to the Orange setting or moving to the Red setting, alongside the self-isolation settings.

77. Implementing a 'Test to Release' requirement will require some planning to operationalise from a communication, legal, and technological perspective. Therefore ahead of the next review, the MoH will work with other agencies, including the Ministry of Social Development from a Care in the Community perspective, to ensure that any future changes to isolation settings can be operationalised with a very short lead in time.

78. Analysis to inform the next monthly review will look closely at the impact of two further options:

    a. reducing both case isolation and contact quarantine from 7 days to 5 days, and

    b. reducing case isolation to 5 days and removing contact quarantine, continuing the requirement to test if symptomatic.

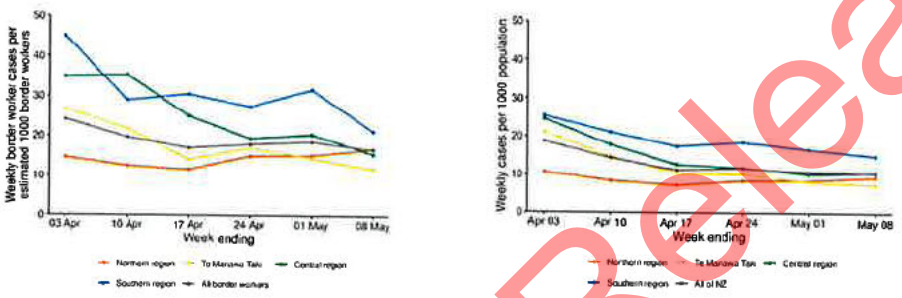
Attachments:	
Attachment A:	Situation update
Attachment B:	Modelling for self-isolation
Attachment C:	COVID-19 Assessment Committee: Review of colour settings and isolation periods 16 May 2022
Attachment D:	COVID-19 Impacts on the Disability Community

Attachment A: Situation update

1. Case numbers peaked in March 2022, with a steady decline that continued to the week of 17 April 2022. Since then, however, daily case numbers have plateaued nationally, with the Northern Region beginning to see a gradual increase. Case rates in border workers are also increasing.
2. Border worker comparisons with community case rates suggest substantial under ascertainment of cases in the community (17 per 1000 versus 10.5 per 1000, respectively), Figure 1.

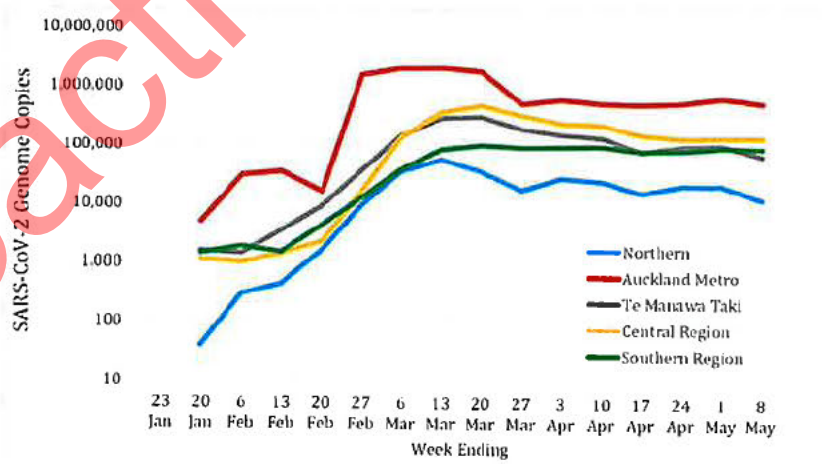
Figure 1: Regional weekly case rate (per 1000) of COVID-19 for (A) border workers and (B) the general population for the weeks ending 27 March to 01 May 2022

(A) *(B)*



3. Infection levels are likely to be higher than the self-reported cases indicate (with a significant number of cases being asymptomatic and / or going unreported), but the proportion of infections that are being reported is not likely to have changed significantly in the last month. Wastewater RNA levels have not decreased since early April 2022 in the Northern Region, and routine surveillance testing of border workers has exhibited a similar long-term trend.
4. Underlying infection appears to be at similar levels as late February 2022, based on evidence by wastewater RNA levels across the motu as indicated in Figure 2.

Figure 2: Trends in SARS-CoV-2 genome quantification from wastewater by region from 6 February to 8 May 2022



5. Nationally, the seven-day rolling average for daily cases is 157 per 100,000 resident population (as at 17 May). This is 7 percent higher than it was seven days earlier. Over the same period, the seven-day rolling average of daily cases rose in all but five District Health Boards (DHBs) – Southern, Wairarapa, Canterbury, Nelson-Marlborough, and MidCentral. Waikato increased by 21 percent, Waitemata and Bay of Plenty by 16 percent, and Tairāwhiti and Taranaki by 16 percent.
6. Modelling indicates a continued increase in R effective based on data to 9 May 2022 with an estimated median Reff of 1.1. For Tairāwhiti, the Reff is 0.6 and for Northland it is 1.3. Auckland DHB, which has driven the Northern Region increases from the past two weeks, has an estimated Reff at 1.1.

Hospitalisations increasing and length of stay likely to increase; deaths are steady

7. Hospitalisations rates have slightly increased over the past month and the death rates remain reasonably steady at around 9 to 17 average death reported per day[5].
8. The 4-day rolling average of hospitalisations is 7.3 per 1000 active cases as of 13 May, an increase from the previous month (12 April 2022) which was 6.6 per 1000 active cases. As of 9am 18 May 1017 people have died with or after COVID-19 infection. Of these, 968 have died within 28 days of being reported as a case.

Ongoing COVID-19 infections are leading to increased risk in vulnerable populations

9. For the 65+ age group, there has been an increase in cases across the country in the week ending 8 May. The Northern region has increased by 8 percent, Te Manawa Taki has increased by 3 percent, Central has increased by 14 percent and Southern has increased by 2 percent. Case rates for those at higher risk of complications or severe illness from COVID-19 aged 45-64 and 65+ age groups, were highest in European or other for 45-64 (11.4 per 1000) and Māori for 65+ (7.8 per 1000).
10. However, the general age distribution of both Māori and Pacific populations are younger than other ethnicities in Aotearoa while also having lower life expectancies. This could mean an increased risk for COVID-19 complications at a lower age. Māori and Pacific People have increased prevalence of other underlying conditions. For 45-64 years Pacific People case rates have increased by 14 percent in week ending 15 May, compared to week ending 8 May.

Variants of concern and community risk

11. There have been 20 cases of BA.4, BA.5, XE and BA.2.12.1 detected at the New Zealand border in the last four weeks. Overall border cases have risen in the last two weeks.
12. Subvariants BA.4 and BA.5 have also been reclassified by the European Centre for Disease Prevention and Control as variants of concern. Evidence indicates a significant growth advantage of BA.4 and BA.5 compared to BA.2. This is likely due to their ability to evade immune protection induced by prior infection (BA.1) and/or vaccination, particularly if this has waned over time.
13. The dominant sub variant in the community continues to be BA.2 and there has been no detection of BA.4, BA.5 or the XE variant. However, there are limitations and coverage issues of whole genome sequencing at present in the system.

[5] This death rate range is different to the latest situation report due to timing of some death reporting.

Attachment B: Modelling for self-isolation

1. MoH drew on two models to inform their advice regarding self-isolation periods. Both models indicated that reducing self-isolation periods results in a significant change in infections and hospitalisations about 15 to 45 days after a policy change. The following four scenarios were run across the models:
   - Baseline - 7 days isolation for cases. 7 days isolation for household contacts, testing on days 3, 7 and if symptomatic;
   - Option One - 5 days isolation for cases, 1 'Test to Release'. 5 days isolation for household contacts, testing on days 3, 5 and if symptomatic;
   - Option Two - 5 days isolation for cases, 1 'Test to Release'. No quarantine for household contacts, testing on days 3, 5 and if symptomatic; and
   - Option Three - 5 days isolation for cases, 1 'Test to Release'. No quarantine for household asymptomatic contacts, no testing unless symptomatic.
2. The first model, which is only able to produce short-term results, found that option one would result in a 17 percent increase in infections and a 15 percent increase in hospitalisations. When compared to the week ending 24 April, this would see the 7-day rolling average for hospitalisations increase to 466 versus 405.
3. This model also looked at the implications of option two - removing self-isolation requirements for household contacts. It found that when combined with the reduced self-isolation periods for case, we would see a seven-day average of 539 hospitalisations (a 33 percent increase) and a 36 percent increase in infections.
4. The second model found that option one (a day 5 'Test to Release' for cases, and a 5-day self-isolation period for household contacts) result in a similar increase in hospitalisations in the short-term. However, the cumulative impact on hospitalisations and cases to the end of 2022 was two to three percent. This means most cases were predicted to occur earlier in the year, but the overall case rate would not be significantly higher than it is currently. This would see about an additional 500 – 1,100 hospitalisations than currently predicted for 2022.
5. This model also indicated that the impact of option three (a day 5 'Test to Release' for cases and no isolation for asymptomatic household contacts) would be a roughly 63 percent (low scenario) to 79 percent (high scenario) increase in hospitalisations in the short-term, with the cumulative impact on hospitalisations to the end of 2022 being 8-11 percent (an additional 1,500 to 4,500 hospitalisations in 2022).
6. Both models assume that the BA.1 and BA.2 subvariants continue to be the dominant variants transmitting through the community. However, we are likely to see new variants of concern, or subvariants of Omicron, that begin to out-compete those currently in circulation in the next six to twelve months[6]. Therefore the lower long-term estimates of the impact of isolation changes should be treated with caution. If a new variant with high immune evasion entered New Zealand, the impacts of any changes could be larger than modelled.

Table 1: The short-term impacts are similar across the two models

Settings	Option 1	Option 2	Option 3
Cases	5 days, test to release	5 days, test to release	5 days, test to release

[6] The BA.4 and BA.5 subvariants of Omicron, that have recently been reclassified by the European Centre for Disease Prevention and Control as variants of concern, have been detected in recent arrivals and may be undetected in the community.

Household contacts	5 days isolation	No isolation, day 3/5 testing with strong precautions	No isolation, test if symptomatic
Model	**Infections**		
Model 1 (NCM[7])	+17%	+36%	+72%
Model 2 (BPM[8])	+5-20%	+23-31%	+66-88%
Model	**Hospitalisations**		
Model 1 (NCM)	+15%	+33%	+65%
Model 2 (BPM)	+1-17%	+22-29%	+63-79%

Table 2: The cumulative impacts over a year are small (using the BPM)

Settings	Option 1	Option 2	Option 3
Cases	5 days, test to release	5 days, test to release	5 days, test to release
Household contacts	5 days isolation	No isolation, day 3/5 testing with strong precautions	No isolation, test if symptomatic
Infections	+2-3%	+2-5%	+5-10%
Hospitalisations	+2-3%	+4-6%	+8-11%

[7] The Network Contagion Model (NCM) consists of a simulated interaction network that represents New Zealand's 5 million resident population, in terms of age, sex, ethnicity, broad home location, workplace and education status, and vaccination status. It simulates population interactions in dwellings, schools, workplaces, and in the community, based on patterns of social interactions, credit card transaction data, allowing cases and outbreaks to be tracked through these interactions.

[8] The Branching Process Model (BPM) uses the interaction network from the NCM to determine the level of interaction each age group has between and within age groups. This, along with the age groups' vaccination and infection status are used to determine the likely case, hospital bed occupation, and fatality rates over a medium to long term. The BPM is used by DPMC for regular COVID tracking.

Attachment C: COVID-19 Assessment Committee: Review of colour settings and isolation periods 16 May 2022

Attachment D: COVID-19 Impacts on the Disability Community

1. The Human Rights Commission (HRC) released the 'Inquiry into the Support of Disabled People and Whānau During Omicron' report on 20 April. This report identifies seven key issues with the COVID-19 response to Omicron:
   - a lack of partnership with disabled people and their whānau
   - communications
   - staying safe during the pandemic
   - support to isolate safely
   - disrupted disability support services
   - health services availability
   - lack of support in education settings.
2. HRC's report contains 14 recommendations, and officials from the ODI are co-ordinating the collation of agencies' actions which respond to, or relate to, HRC's recommendations. The Disability Rights Commissioner has stated that "since launching [her] Inquiry, the government has responded positively and with urgency to some of the issues I and others were raising".

Progress has been made by agencies to help alleviate and/or respond to the concerns raised by the community. These steps include the provision of RATS to disability providers and specialist schools, developing systems to track outcomes for disabled people, and clear masks for Deaf and hard of hearing people. Work continues to address other issues raised by the disability sector and is monitored via an 'All of Government COVID-19 Disability Response Action Tracker'; which is reviewed fortnightly by COVID-19 Ministers.