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

Proactive Release

The following documents have been proactively released by the Department of the Prime Minister and Cabinet (DPMC), on behalf of the Minister of Health, Hon Dr Ayesha Verrall:

COVID-19: Strategy for Post Winter

The following documents have been included in this release:

Title of paper: COVID-19 Strategy for Post-Winter (SWC-22-SUB-0118 refers)

Title of minute: COVID-19 Strategy for Post-Winter (SWC-22-MIN-0118 refers)

Title of minute: Report of the Cabinet Social Wellbeing Committee: Period Ended 1 July 2022 (CAB-22-MIN-0251 refers)

Some parts of this information release would not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act). Where this is the case, the relevant section of the Act that would apply has been identified. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Key to redaction codes:

- section 9(2)(f)(iv), to maintain the confidentiality of advice tendered by or to Ministers and officials;
- section 9(2)(g)(i), to maintain the effective conduct of public affairs through the free and frank expression of opinion; and
- section 9(2)(h), to maintain legal professional privilege.

Office of the Minister for COVID-19 Response

Cabinet Social Wellbeing Committee

COVID-19: Strategy for post winter

Proposal

1 This paper reports back to Cabinet on changes to our COVID-19 strategy, and the legal and institutional settings to ensure our approach for managing COVID-19 is sustainable over the longer term.

Relation to Government priorities

2 This paper concerns the Government's response to COVID-19.

Executive Summary

3 Throughout the pandemic, we have evolved our strategy for managing COVID-19. We have kept public health considerations central to our approach, shifting from an elimination strategy to one of minimisation and protection, as immunity increased and the characteristics of the virus changed. Our approach to the border has also evolved as the relative risk posed by international arrivals has decreased. Through winter we will continue to rely on the minimise and protect strategy and the COVID-19 Protection Framework (the Framework) to minimise the virus's impact on people and our health system.

4 All going to plan, after winter 2022, I am proposing to introduce a new strategy for managing COVID-19. Preparedness, protection and resilience, and stability will form the basis of this strategy and it will be delivered using a set of 'baseline' and 'reserve' measures. Baseline measures will remain in place all the time and support us to maintain and build resilience and provide protection. Measures such as vaccination campaigns, targeted protection and public health campaigns will be used in baseline. In situations where the risk posed by COVID-19 escalates (e.g. there is a new variant of concern), and more restrictive measures are justified, reserve measures will be available to strengthen our response. In these circumstances, measures such as broad-based self-isolation, mandatory mask use and gathering limits could be used.

5 Under the new COVID-19 strategy, we will seek to provide greater stability and certainty and harness the lessons from our previous two years with the pandemic. We will focus on strengthening our baseline measures to build COVID-19 resilience, promote community wellbeing, and target protection to those most vulnerable to the virus. We will do this by prioritising access to booster shots and anti-viral therapeutics, continuing to make masks and other PPE available, and strengthening guidance on screening testing in highly vulnerable places, such as Aged Residential Care and disability services facilities. Effective public health messaging will be a key element to health promoting behaviours.

6 To ensure we are well placed to continue responding to the current outbreak, and to any future variants of concern or pandemics, under this new strategy, I am proposing to shift our legislative approach away from an emergency response-based framework to a more enduring legislative framework. Our institutional functions will also need to change. I am proposing a staged transition of these functions, which will see a move to decentralised arrangements within government, with the health agencies becoming responsible for the ongoing coordination of COVID-19 over time.

7 Collectively, our overarching strategy, legislative arrangements, and institutional arrangements will reflect a prepared, protective and resilient, and stable approach. We will be well placed to respond to the most likely scenarios for how COVID-19 will develop over the long term and remain vigilant and prepared to react to worse outcomes.

8 In August, I will report back to Cabinet with more detailed policy proposals on the approach to shift legislative powers and instruments to a more enduring legal framework.

9 I propose that Cabinet consider the timing of our adoption of this new strategy in September. At this point, we will be through winter and the Omicron outbreak may have waned to the extent that it is no longer putting the health system under pressure. September is also the time that the Epidemic Preparedness (COVID-19) Notice 2020 (Epidemic Notice) will next be considered for renewal. These reviews are important both to ensure that only proportionate measures are in place and to reduce the risk of undermining social licence for public health powers now and in the future.

Introduction

10 In this paper I seek Cabinet's agreement to:

10.1 the new strategy for managing COVID-19, including the future of the Framework; and

10.2 reconfigured institutional settings arrangements to deliver this new COVID-19 strategy.

11 Information about the work programme for the legislative settings required to deliver the strategy is also provided.

Background

Strategy history

12 Throughout the pandemic our strategy has evolved to respond to changes in the virus, protections we have available, and society's response to the pandemic. Public health considerations have remained central to our approach. Initially, in the face of a novel virus for which we had no immunity, the elimination strategy allowed us the freedom to retain as normal as possible lives within New Zealand while keeping mortality and morbidity at

some of the lowest levels in the world. The public health measures in the Alert Level system included capacity limits, self-isolation, mandatory masking, and record keeping supporting effective contact tracing. Managed isolation and quarantine of international arrivals was key to this strategy.

13 Following very high uptake of vaccination, we could shift our strategy to minimisation and protection using the COVID-19 Protection Framework, with the addition of My Vaccine Pass to the public health restrictions already in use. For the Delta variant, the focus was on tight suppression, where the harmful impacts were minimised through individual immunity, collective immunity, and public health measures that kept the rate of spread low.

14 We shifted our strategy again for the Omicron variant, which had higher transmission and reduced clinical severity. For the first time we shifted away from a low transmission model of protection. We recognised the more transmissible variant would lead to widespread transmission in the community and relied on high vaccination immunity and reducing the peak hospitalisation rate. We continued to rely on rights-limiting public health measures, including mandatory vaccination for some workforces, broad-based self-isolation, capacity limits, and mask requirements.

Future pandemic trajectory

15 The World Health Organization Strategic Preparedness, Readiness and Response Plan (WHO), the United Kingdom Health Security Agency (UKHSA), and the Department of the Prime Minister and Cabinet's (DPMC's) Insights and Reporting team have produced documents that outline possible scenarios for the long-term development of COVID-19. On Monday 13 June, Cabinet also considered five hypothetical variant scenarios, which were developed by the Ministry of Health to enhance All-of-Government preparedness for future variants of concern [CAB-22-MIN-0223].

16 The WHO, UKHSA and DPMC coalesce around a most likely picture of declining severity over time, as immunity through vaccination and historical infection builds, but with potential for disruption from new variants along the way. All agencies note the potential, albeit with lower likelihood, for more severe disruption caused by a variant with greater severity and levels of immune escape.

17 Because the evolution of this virus is so unpredictable, our strategy needs to set us up to move into the future based on the most likely outcomes, while remaining vigilant and prepared for worse outcomes. Our management of COVID-19 will increasingly be integrated into broader pandemic planning and public health systems.

18 Looking out to the long-term in New Zealand, with high immunity, high transmission and likely repeated waves of new variants, we need to adapt our strategy to optimise across our longer-term health, economic and social outcomes. *The COVID-19 Response for Post-peak Omicron* paper signalled our intention to shift to a new strategy once we were past the winter stage of the Omicron outbreak [CAB-22-MIN-0086]. The *COVID-19: Confirming New*

Zealand's Approach to Variants of Concern paper signalled how the approach to variants would be embedded in the new strategy [CAB-22-MIN-0223]. This paper formally proposes the new strategy and the legislative and institutional arrangements needed to give effect to it.

International COVID-19 Strategies

19 Most countries' long-term strategies are now focusing on endemicity. Countries such as the US, Australia, Denmark, Italy, Germany, Singapore, Spain, Thailand, and the UK are focused on an accepting endemicity approach to COVID-19 and its subsequent variants. There is an emphasis in long-term plans on maintaining health sector capacity, high levels of vaccination, and methods to keep patients out of the hospital system. China is that last major economy still maintaining a zero-COVID strategy. It is continuing to employ resource intensive mass testing and case surveillance, and enforcing lockdowns, strict quarantine and isolation.

20 In March 2022, the United States launched a Test to Treat Initiative, including 'one-stop' facilities to access tests and treatments, which will enable people who receive a positive test to immediately collect therapeutic medication from the testing centre. It will also add at-home tests, anti-viral therapeutics and masks for the general population to the national stockpile for the first time.

21 Earlier this year, South Korea introduced a new strategy of 'select and focus'. It focuses its resources on the elderly and vulnerable, including assistance e.g. in-home treatment for the severely ill. People under 60 years of age without underlying medical conditions are expected to manage on their own.

Proposed new strategy for managing COVID-19

22 I propose that our new COVID-19 strategy be prepared, protective and resilient, and stable.

22.1 **Prepared** means we are prepared to respond to new variants with appropriate measures when required. This includes having the measures in place, including surveillance, to know when and how we might need to respond.

22.2 **Protective and resilient** means we continue to build resilience into the system, and continue both population and targeted protective measures. We take measures as part of our baseline that reduce the impact on individuals, families, whānau, communities, businesses, and the healthcare system that will make us more resilient to further waves of COVID-19;

22.3 **Stable** means our default approach is to use as few rights and economy limiting measures as possible. As part of our baseline there are no broad-based legal restrictions on people or business, and no fluctuating levels of response to adapt to.

23 By building resilience, we will reduce the baseline impact of COVID-19 on people and the health system. We need to focus on reducing the impact on those most likely to be susceptible to the impacts of COVID-19, better enabling them to go about their usual lives. Prior to implementing the new strategy, officials will work on a communications approach to explain simply and clearly what it means for people.

24 Our new strategy needs to promote stability and confidence. We need to support people and businesses to have the confidence to plan without the constant concern about disruption. To this end, we will remove the COVID Protection Framework when it is no longer required. This is anticipated to be post winter and discussed more in paragraphs 33 to 36 below.

25 However, as per the Cabinet paper *COVID-19: Confirming New Zealand's Approach to Variants of Concern*, we also need to be prepared for worse outcomes – including the worst- case scenario set out by the Ministry of Health in its Strategic Framework for COVID-19 Variants of Concern [CAB-MIN-0223]. The Cabinet paper outlined our readiness work to respond to new variants.

26 Although not formally a part of this strategy, recovery from the impacts of the pandemic will continue to remain a focus across government. Individual agencies will continue to progress individual work programmes to support economic, social and system (e.g. the health system) recovery.

27 We will deliver this new COVID-19 strategy with a 'baseline and reserve' approach:

27.1 The **baseline** consists of protective and resilience measures that will cumulatively help to ensure the burden on the health system is minimised (both via improving the capacity and capability of the health system, and by reducing hospitalisations and death), our communities are strengthened, and those who are vulnerable feel safe and are less at risk of infection or poor outcomes from COVID-19 infection. These measures largely move away from mandatory requirements in legislation, and instead rely on voluntary uptake in many instances, increasing the overall stability of our response. They can be in place at any time and be scaled as required.

27.2 **Reserve** measures, most of which are rights limiting, are measures that rely on powers triggered in particular circumstances, such as when an epidemic notice is in force. They involve a more acute trade-off between limiting transmission, economic impacts and impacts on people's rights, which is why these measures are not part of our baseline measures and would only be used if proportionate to do so, guided by public health advice and an assessment of risk. Being ready to use these measures is the 'prepared' aspect of the strategy.

28 We expect to be able to spend most of our time using only baseline measures. This is a notable shift from the current approach, which includes mandatory requirements in legislation (e.g. on-arrival testing and vaccination

for some people travelling to New Zealand). When effective, with widespread public uptake, the baseline measures collectively increase our capacity to absorb COVID-19 impacts, meaning we will be less likely to need to use more restrictive tools when a new variant emerges. Investment in baseline measures represents a significant ongoing expense for the Government. It is important that there continues to be assessment of the scale at which individual public health COVID measures should continue to operate at, including consideration of the cost, and that work towards managing COVID activities within baselines is progressed. Social licence will also be important for the effectiveness of both baseline and reserve measures.

29 Reserve measures give us the ability to respond if required, proportionate to risk. This means that we are prepared to respond to and minimise the impact from any significant waves of the virus or more severe variants that could circulate in future. Due to the rights limiting nature of most of these measures, we should be clear about the key considerations surrounding their use.[1] These include:

29.1 their effectiveness against the variant,

29.2 that the measure's benefits outweigh its costs across social, cultural, economic, and (non-COVID) health domains, and that no combination of lesser restrictive measures would be sufficient to achieve the intended health effect (evaluation of this also includes whether there is social licence to use the measure, our ability to operationalise the measure in the necessary timeframe to have the desired health effect and Treaty of Waitangi obligations); and

29.3 that the measure does not limit rights or is a justified limitation of rights set out the in the Bill of Rights Act based on public health advice, and

29.4 that consideration is given New Zealand's international obligations when using the measure.

30 The baseline and reserve measures are shown below in Table 1:

Table 1. Baseline and Reserve measures for responding to COVID-19 risks

Baseline measures (non-exhaustive list)
Maximising population immunity through **vaccination,** with priority measures for the most vulnerable population groups and their carers (including disabled persons and seniors, education, and healthcare workers), with particular regard to Māori and Pacific (Cabinet will consider a report back on the Vaccine Strategy in July). **Contact tracing** and isolation in accordance with the Health Act 1956 (as for other infectious diseases). This includes calling cases and contacts, collection of personal details, collecting details of contacts, asking health questions and collecting exposure event information. This also includes special powers that are already used in the Health Act (refer Part 3A) that enable a Medical Officer of Health to e.g. give directions to an individual posing a public health risk from an infectious disease, such as pertussis.

[1] The decision-making process was detailed in *The COVID-19: Confirming New Zealand's Approach to Variants of Concern* Cabinet paper [CAB-22-MIN-0223]

Investment in the healthcare system, including to enable continued provision of Māori whānau-centred and Pacific community responses and to improve community access to care more broadly.

Protecting people against severe illness with improved use (including via improving accessibility) of **anti-viral therapeutics**, targeting those most vulnerable to severe illness and long-term effects.

Communications, guidance and support to **promote public health behaviours**, such as the use of masks and ventilation for higher-risk activities (such as very large gatherings), and targeted messaging (e.g. 'stay at home if you are sick' and 'wearing a mask inside protects vulnerable people').

Targeted protection to those most vulnerable to COVID-19 including the elderly, Māori and Pacific Peoples, disabled people, and those with co-morbidities or suppressed immune systems. This will include strengthened guidance on screening testing in highly vulnerable places, such as Aged Residential Care (ARC) and disability services facilities, or prisons, and ensuring testing modalities are readily available and accessible; prioritising access to regular booster shots; and maintaining the availability of appropriate PPE.

Continued promotion of **infection prevention** and controls (IPC).

Improved **communications, data, information,** and availability of supporting **technology** for individuals, whānau, faith leaders, communities, schools, and businesses to help manage risk (and avoid or counter disinformation) at the PCBU[2], hapū, whānau, and individual level. This will include improved provision of up-to-date information on the latest variants, and improved ventilation.

Surveillance and voluntary COVID-19 testing to understand our level of risk and prevalence of new variants, inform measures to help reduce onwards transmission, and enable timely access to therapeutics and clinical care. Surveillance is also important to evaluate our response.

Income support, employment services, and community service provider support through the Ministry of Social Development (MSD). This includes wraparound **holistic support** through hapū, iwi, Whānau Ora and other community providers.

Evaluation and research of the effectiveness of measures.

Reserve measures

May include all or any of the following:

Isolation arrangements including mandatory requirements for cases or contacts to isolate on the direction of a health official, other than a Medical Officer of Health, or which apply without specific personal communication or notice to the individual. Reserve powers could also include requirements on third parties to support contact tracing efforts or provide necessary information, including record keeping requirements for businesses (such as use of a QR code and/or other record keeping to identify individuals to be contacted in case of an exposure event).

Targeted vaccination requirements to protect vulnerable population groups, or mitigate the risk of new variants entering the country (e.g. worker vaccination mandates).

Shifting public health behaviours from guidance to legal requirements (e.g., making it a requirement to return a negative test before entering an ARC or other highly vulnerable place).

Implementing population level legislated restrictions (e.g. mandatory broad self-isolation, mandatory mask wearing, gathering limits, mandatory use of vaccine passes).

Movement restrictions (either localised, for example targeted at types of entities, regional, or national).

Broad quarantine and isolation requirements.

Border measures, such as mandatory testing requirements or in extreme cases partial or complete closures.

[2] PCBU – Person in charge of a business or undertaking – responsible under Health and Safety at Work Act for the safety of workers and customers

Funding and supports – including to mitigate the impact of severe restrictions and support compliance with public health measures in limited circumstances.

31 Table 1 above lists the baseline programmes at a high level and further work will be done to develop the programmes underneath these headlines by the Ministry of Health, Health New Zealand and the Māori Health Authority. The principles of the Pae Ora Act 2022 will be important to the design of the baseline programmes. These principles include engaging with Māori to develop, deliver, and monitor services and programmes designed to improve hauora Māori outcomes.

32 Delivering this new COVID-19 strategy depends on the right legislative framework and institutional arrangements being in place. The legislative framework ensures the legislative powers and instruments needed to implement the strategy's baseline and reserve measures are available. The institutional arrangements will ensure the COVID-19 system remains fit for purpose and well placed to deliver the strategy. The following sections discuss the timing of the shift to the new strategy and discuss these legislative settings and institutional arrangements.

Repealing the COVID-19 Protection Framework and moving to the new strategy

Consideration of future of the Framework in September after winter

33 Our 2022 winter strategy and the COVID-19 Public Health Response (Protection Framework) Order 2021 (the Framework Order) are needed now because of the expected number of cases and other pressure on the health system over winter. However, after winter we expect this pressure to ease. Therefore, I propose that in September, Cabinet considers whether the Framework has served its purpose and we should move to implementing a baseline and reserve approach. The Epidemic Notice will also be considered for renewal in September (discussed further below).

34 The Framework was designed for Delta in October 2021 and amended for Omicron in February 2022. While we have also updated the settings within the Framework as new information has come to hand, a complete refresh or repeal may be desirable after winter, particularly if Omicron is waning.

35 Our decision-making will be guided by public health advice, impacts on vulnerable people and Māori, and a broader system perspective of whether the Framework Order continues to be justified and proportionate in the post-winter period.

36 Even if a decision is taken to the revoke the Framework Order in September, the COVID-19 Public Health Response Act 2020 (COVID-19 Act) will remain in force until May 2023 (unless repealed earlier). This means the empowering provisions in that Act, to make or amend COVID-19 Orders, will continue to be available to us after the Framework Order is revoked, subject to the legislative conditions for making these orders being met. For example, if a new variant of

concern produces conditions that justify the making of a new Epidemic Notice or Prime Ministerial authorisation, a new COVID-19 Order could be made implementing reserve measures to respond to those conditions. If no reserve measures are justified or proportionate after the Framework Order is repealed, only the baseline measures will be in place to deliver our new strategy (until any change in risk requires implementation of reserve measures).

The Epidemic Notice and COVID-19 Orders

37 In line with my obligation to keep COVID-19 orders under review, some COVID-19 Orders have been revoked that are no longer required to support our current response. Recently, we revoked Orders relating to the use of vaccine passes, required testing and medical examination of affected persons. The Order relating to mandatory vaccination for certain workforces was limited. There are now 13 Orders under the COVID-19 Act.

38 Every three months since the pandemic was declared, the Prime Minister has renewed the Epidemic Preparedness (COVID-19) Notice 2020 (the Epidemic Notice), with the agreement of the Minister of Health and on recommendation of the Director-General of Health. All the COVID-19 Orders, including the Framework Order, depend on an Epidemic Notice being in force. The next Epidemic Notice renewal point is 17 September 2022.

39 The Prime Minister may only renew the Epidemic Notice if she is satisfied that the effects of the outbreak of COVID-19 are likely to disrupt or continue to disrupt essential governmental and business activity in New Zealand significantly. When that condition is no longer met, and the Epidemic Notice cannot be renewed, it will expire. At that point, and while the COVID-19 Act remains in force, instead of relying on the Epidemic Notice, new COVID-19 orders (or amendments to existing Orders) can only be made if the Prime Minister specifically authorises their use.

40 s9(2)(h) [redacted]

Legislative settings: transitioning to an enduring legislative framework

41 I propose to shift our legislative approach to support the new strategy. Other than the powers in the Health Act 1956, the measures we now rely on to respond to COVID-19 will not be available after the COVID-19 Act is repealed in May 2023 (if not earlier). We need to make sure that the reserve measures are housed in enduring emergency legislation, so they are available when needed after the COVID-19 Act is repealed.

42 Most baseline measures will not require any legislative basis e.g. guidance to stay home if sick. However, some are currently in emergency legislation. To ensure they are available any time, irrespective of whether we are in an emergency, we need to move them into non-emergency, business-as-usual legislation. This transition needs to occur as soon as possible. An example includes the New Zealand Traveller Declaration System.

43 DPMC is coordinating a project across government to identify the measures we need to transition. I propose to transition these measures in two tranches:

43.1 s9(2)(f)(iv) [redacted]

43.2 Reserve (or COVID-19 emergency) measures could be transitioned later, via a bill to be enacted by May 2023 to align with the ultimate expiry of the COVID-19 Act. This will ensure these reserve measures are available after the COVID-19 Act is repealed. It will also ensure appropriate legislation is in place to provide a 'stop-gap', or the ability to temporarily respond to future variants of concern or pandemics while Parliament considers bespoke solutions.

44 Officials are working through detailed proposals to support this transition, including identifying the measures requiring transition, and best legislative home. The form of the legislation to be enacted by May 2023 is also still being considered – this could be an amended version of existing legislation (e.g. the Epidemic Preparedness Act 2006) or a new bespoke infectious diseases piece of legislation. I will report back to Cabinet with more detailed policy proposals to implement this transition in August 2022.

45 Separate from the work being progressed by DPMC, several agencies have included proposed amendments to future-proof their systems after the COVID-19 Act is repealed, in their own legislative amendment work programmes. s9(2)(f)(iv) [redacted]

Institutional settings: transitioning to a decentralised, more sustainable operating model

46 The COVID-19 pandemic has required centralised decision-making and operational coordination, as well as integration of strategy and policy across sectors. To this end, the COVID-19 Group in DPMC was established in July 2020, following a rapid review of the Government's response undertaken by Rebecca Kitteridge, Dave Gawn and Sir Brian Roche. Previously, the All-of-Government response was coordinated by the National Crisis Management Centre (NCMC).

47 Two subsequent reviews of the COVID-19 Group were undertaken in August 2020, with findings indicating a need for the evolution of central functions and a plan for maintaining these functions for two further years. Both reviews recommended that line agencies be responsible for delivery as much as possible, but that the overall work plan and strategy be developed and overseen from the centre.

48 In December 2020 Cabinet endorsed a broadened scope for the COVID-19 Group, formally establishing it as a business unit of DPMC. The Group was mandated with "coordination of cross-agency response activities and integration of advice" [CBC-20-MIN-0100], by delivering strategy and policy integration; systems readiness and planning; insights and reporting; risk and assurance; and communications and engagement.

49 At a governance level, the All-of-Government COVID-19 response has benefited from several arrangements to ensure agencies remain well informed, coordinated, responsive and able to deliver on the government's strategy. This has included a National Response Leadership Team (NRLT), the COVID-19 Chief Executives Board (CCB), the Care for the Community Chief Executives Group and thematic senior officials and operational level groups. Only NRLT was established by Cabinet [CAB-20-MIN-0387].

50 Day-to-day responsibility of centralised functions has rested with the Deputy Chief Executive of the COVID-19 Group, DPMC with strategic leadership resting with the Chief Executive of DPMC and more recently with the Chief Executive, COVID-19 All-of-Government Response.

51 Central coordination of our All-of-Government response has served us well, leveraging the capability of line agencies to deliver on the Government's COVID-19 strategy, particularly during the emergency conditions we have been in. I consider the DPMC COVID-19 Group has delivered high quality, timely advice and outputs, across the full range of its functions.

52 We have been evolving our response since the shift from elimination to the minimise and protect strategy. This has included a move away from high levels of centralised decision making, to a greater emphasis on responsibility lying with sectors and individuals, as well as the reopening of our international borders. This has reduced the workload at the centre and this transition planning is a further consequence of that evolution. Some interagency groups have adapted to decreasing demands by rationalising the frequency that they

meet and reviewing their ongoing utility. While NRLT remains a live construct, it is currently 'on ice' by mutual agreement of its membership.

53 The Public Sector Act 2020 requires a higher level of cross sector collaboration and a greater engagement with communities. There have been valuable lessons throughout our COVID-19 response, including the strength of community-led strategy and action, and the impact that Māori communities can have in responding to complex issues when they are enabled to do so. My expectation is that these lessons are not lost as we transition to the next phase of our COVID-19 response.

54 As part of its consideration of New Zealand's approach to variants of concern [CAB-22-MIN-0223], Cabinet agreed that Public Sector Chief Executives would keep their COVID-19 preparedness under review to ensure they remain fit for purpose across the range of variant scenarios. Cabinet also agreed that COVID-19 Ministers would be informed of any significant issues that may impact New Zealand's ability to react quickly and reactivate or scale-up measures if required.

55 As we transition to the next phase of our response, we need to ensure the COVID-19 system remains fit for purpose and well placed to deliver on the new strategy, with the Ministry of Health remaining the lead response agency. I consider it critical that Ministers are provided ongoing assurance that the Government's response to COVID-19 will continue to be effectively coordinated, driven by an integrated strategy and policy response, and prepared to respond with resilience to a resurgence or new variants.

56 The Chief Executive COVID-19 All-of-Government Response has led an analysis of existing systems functions and governance structures with a view to transitioning our response to an operating model appropriate for a non-emergency context. This work has been undertaken in close consultation with Public Service Chief Executives and has included meetings with Ministers, the COVID-19 Chief Executives Board (CCB); Chief Executives of Health New Zealand and the Māori Health Authority; and Chairs of the Independent COVID-19 Advisory Groups.

57 s9(2)(f)(iv) [redacted]

58 I am mindful that as we take forward the transition, New Zealand is in the midst of a once in a generation health system reform process. I anticipate that this will require the health system to continue to evolve to meet the functions needed to sustain our COVID-19 response and that the transition of functions will need to be well-timed and managed to mitigate risk.

59 s9(2)(f)(iv) [redacted]

Which systems functions are needed on an ongoing basis?

60 On the basis of the analysis and consultation led by the Chief Executive COVID-19 All-of-Government Response, I consider that the following high-level core functions will be required, at least on an interim basis, to support the new COVID-19 strategy:

60.1 Cross-Agency Coordination: this continues to be a function important to provide assurance that the system can be ready to be scaled up if needed, that there is an enduring cross-agency perspective, and that the response continues to be informed by economic and social aspects. This function also provides a supportive mechanism for the governance arrangements for the system – providing a mechanism by which Ministers and Chief Executives can be kept updated and have confidence that they will be engaged with the system at the right time.

60.2 Public Health Advice: our response must be centred on public health advice, drawing from the surveillance systems in place and public health intelligence, taking an innovation focused and science-led approach informed by the Public Health Risk Assessment process.

60.3 Policy and strategy: ongoing strategic framing, policy and legislative work will be required, and this must be coherent and continue to reflect an All-of Government view, reflecting the Crown's Te Tiriti obligations and the significant economic, social, and fiscal aspects of the COVID-19 pandemic response. Policy development should be grounded in lessons learned from the past, and informed by data, insights, and research. Legislation will need to be coordinated coherently, ensuring that timing and co-dependencies are well-managed.

60.4 Operational response and readiness: a resilient and equitable health system, including Health New Zealand and the Māori Health Authority will be at the core of the ongoing operational response to COVID-19 and critical for the clinical care pathways, treatment, and vaccination.

60.5 COVID-19 Communications & Engagement: inclusive, culturally appropriate, and accessible digital and non-digital communications and engagement are fundamental to continued public health and social measures. This will be particularly important as we continue to transition to a greater emphasis on responsibility lying with the community. There will also be an ongoing need for effective science communication as part of public health messaging.

61 With the exception of Public Health Advice and health system aspects of the response, most of these core functions are currently led from the centre by DPMC's COVID-19 Group, with significant input from line agencies. I expect that in future health sector agencies will coordinate the All-of-Government response for most of these functions.

A plan for decentralisation of functions

62 I consider functions should be decentralised as soon as possible. The timeframe for transition will be driven by the readiness of the receiving agency to take on functions, which will in some cases include the transfer of human resources, infrastructure, and legislative functions.

63 I anticipate a phased transition of functions currently residing within DPMC's COVID-19 Group as outlined below:

Existing DPMC COVID-19 Group functions	**Host agency (tranche 1) August – December 2022**	
nsights and reporting (including modelling)	Ministry of Health (Public Health Agency)	
Readiness and planning coordination	Ministry of Health	
Communications and engagement	Health NZ / Ministry of Health and border agencies	
Risk and assurance	Revert to accountable line agencies	
	Host agency (tranche 1) August – December 2022	**Host agency (tranche 2) January - June 2023**
Strategy and policy coordination	DPMC	DPMC or Ministry of Health

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

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

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

[3] There are some more detailed functions also held by the DPMC COVID-19 Group, for example, the Geographic Information System (GIS) capability, which will need to be placed in accordance with the principle of transitioning to the agency best placed to deliver.

67 On this basis, I recommend that Cabinet consider two options for the timing of the transition of the All-of-Government policy and strategy function from COVID-19 Group to the Ministry of Health:

67.1 Option 1: all policy and strategy functions transitioned to the Ministry of Health no later than 31 December 2022; or

67.2 Option 2: policy and strategy functions be maintained within the COVID-19 Group at DPMC until the next round of legislative reform has been completed, with functions transferred no later than 30 June 2023 (with resourcing commensurate with workload). [My preferred option]

68 s9(2)(g)(i)

69 s9(2)(g)(i)

70 I anticipate that there will be no 'one size fits all' approach taken to the transfer of functions given the need for continuity at the systems level to support our ongoing response. The due diligence process between the DPMC COVID-19 Group and line agencies will provide assurance that institutional knowledge is not lost and that functions are transitioned to agencies best placed to deliver.

71 The COVID-19 Group communications and engagement function will, for example, begin a gradual transition as Health New Zealand and the Māori Health Authority build up. Border agencies will continue to amplify Reconnecting New Zealanders/border communications through existing channels. The due diligence process will determine the future of the Unite Against COVID-19 communications channels.

72 s9(2)(g)(i)

73 I anticipate the phased transition of communications and engagement functions, as well as most other functions, will be complete no later than the end of December.

74 I propose that a small group of Ministers be authorised to take decisions as required on the timing and appropriation changes (if any), consistent with the high-level transitional arrangements outlined in this paper. This group will be the Prime Minister, the Minister of Finance, the Minister for COVID-19 Response, and the Minister of Health.

A plan for streamlining governance

75 Our COVID-19 system has benefited greatly from the various governance and operational groups that have been established to coordinate and deliver our response. As we transition our response, I consider there is scope to consolidate our existing approach.

76 s9(2)(f)(iv), s9(2)(g)(i)

76.2 A mechanism for Chief Executives of agencies closely engaged with COVID-19 to continue to convene, as required.

77 s9(2)(f)(iv), s9(2)(g)(i)

78 Given this, I also recommend that the NRLT be formally disestablished. It is no longer required to help guide the All-of-Government COVID-19 response, as it was when initially established and mandated by Cabinet. As previously noted, while the NRLT remains a live construct, it is currently 'on ice' by mutual agreement of its membership.

Key milestones in our transition planning:

Milestone/Activity	**Timeframe**

Cabinet considers high level transition plan arrangements	July 2022
DPMC undertakes an exercise to ensure system readiness to respond to a new variant of concern, prior to any functions transfers	July - September 2022
Tranche 1 functions transition from the COVID-19 Group at DPMC to line agencies	August – December 2022
Tranche 2 functions transition from the COVID-19 Group at DPMC to line agencies	January – no later than 30 June 2023
Progress update briefing on transition provided to Ministers with Power to Act	February 2023
Transition of all accountabilities complete	No later than 30 June 2023

Next steps and communications

79 I will report back to Cabinet in early August with more detailed policy proposals to implement the Future COVID-19 Legal Framework.

80 I will report back to Cabinet in September with a paper addressing the future of the Framework Order and timing to shift to the new strategy.

Financial implications

81 The shift in strategy outlined in this paper does not require additional funding. This is because the baseline measures (e.g. Ministry of Social Development income support, employment services and community service provider support) are already funded. Funding through to 31 December 2022 was provided for the COVID-19 health system response in SWC-22-MIN-0054 and for vaccine purchasing and rollout in SWC-22-MIN-0057 (confirmed in CAB-22-MIN-0132).

82 Investment in baseline measures does represent a significant ongoing expense for the Government. It is therefore important that there continues to be assessment of the scale at which individual public health COVID-19 measures should continue to operate, including consideration of the cost, and that work towards managing COVID-19 activities within baselines is progressed. Ongoing economic impact needs to continue to be a key consideration in the use of both baseline and reserve measures, particularly given the high economic cost of rights-limiting reserve measures.

83 s9(2)(f)(iv) [redacted]

[redacted]

Legislative implications

85 There are no legislative implications from the proposals in this paper. The transition of reserve measures to more enduring emergency legislation, and baseline measures to existing non-emergency legislation, will have legislative implications. I will provide more information when Cabinet considers detailed proposals to support this transition in early August 2022.

Impact analysis

Regulatory Impact Statement

86 The high-level strategy proposed in this paper on the approach for managing COVID-19 over the longer-term does not have immediate legislative or regulatory implications. A Regulatory Impact Statement will be provided in early August 2022 to support Cabinet's decisions on more detailed proposals for the transition to the new strategy including the transition of the baseline measures to existing non-emergency legislation and the reserve measures to a more enduring legislative framework.

87 The Treasury's Regulatory Impact Analysis team has determined that the transfer of COVID functions to health entities is exempt from the requirement to provide a Regulatory Impact Statement on the grounds that it has no or only minor impacts on businesses, individuals, and not-for-profit entities. The transfers involve changes to the internal administrative and governance arrangements of the New Zealand government".

Population implications

88 Our experience has highlighted that the burden of COVID-19 does not fall equally. Some people are at much higher risk of adverse health outcomes from the virus, and disproportionate socio-economic impacts related to our response measures. Risk factors include vaccine status, age, sex/gender, ethnicity, pregnancy, co-morbidities, disability, mental health and addictions, material deprivation and poverty, occupation, household characteristics, high risk settings, and inadequate access to health care.

89 To mitigate the risk of inequitable outcomes, it is proposed our baseline measures include targeted protections for the most vulnerable, developed alongside these groups. For example, strengthened guidance on screening testing in highly vulnerable places, such as ARC, prisons and disability services facilities, and greater accessibility to tools that prevent risks of transmission or severe disease, including ensuring testing modalities are readily available and accessible; prioritising access to regular booster shots; and maintaining the availability of appropriate PPE. Particular consideration of accessibility to tools that prevent risks of transmission or severe disease should be considered for iwi, communities, and ethnic groups such as Māori and Pacific Peoples where transmission rates have been higher than for non-Māori, non-Pacific Peoples. Health New Zealand and the Māori Health Authority intend to undertake a health equity impact assessment of their operational COVID-19 activities in the context of the new strategy.

90 It is possible that some baseline measures could increase digital exclusion issues eg, if meetings are held virtually rather than in-person. This potential issue should be considered as part of any further development of baseline measures, particularly for supporting technology, and will be addressed as part of *Digital Strategy for Aotearoa* to set a clear direction for all New Zealanders to have the tools, skills, and confidence they need to participate in an increasingly digital society.

91 In the event that the public health risk increases, and reintroducing reserve measures has been mooted, consideration is needed for an equitable approach for populations who are more likely to feel the disproportionate impacts of COVID-19, in particular the Crown's duty to actively protect Māori health outcomes. People who are more vulnerable to the impacts of COVID-19, including disabled and elderly people, Māori, and Pasifika, have previously indicated a preference for a more cautious approach to managing COVID-19 and have favoured measures that, although limit peoples' rights, provide greater safety against the public health risks of COVID-19. There is a tension the Crown has to weigh up in making these decisions between active protection under the Treaty and protecting rights under the Bill of Rights Act.

92 As the systems transition will be driven by the readiness of receiving agencies to take on functions from the centre, I expect New Zealanders will receive an equal or better level of service from the public service. The transition should be seamless from the perspective of the public.

Te Tiriti o Waitangi Analysis

93 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 our response to and future management of COVID-19, 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.

94 The current outbreak has so far had a disproportionate impact on Māori. Māori are at higher risk of COVID-19 infection, hospitalisation, and death due to inequitable vaccination rates, incidence of pre-existing health conditions and structural factors (e.g. housing deprivation). A secondary impact of this is that Māori service providers are experiencing high degrees of workforce fatigue. Preparedness activities must account for this, and effort must be made to support the recovery and sustainability of these providers so that they can continue to best meet the acute and longer-term COVID-19 needs of their communities.

95 Early in our COVID-19 response, locally provided and whānau-centred responses by Whānau Ora Commissioning Agencies, Iwi and Māori providers to whānau Māori, including tāngata whaikaha Māori, during the pandemic have enabled a rapid, flexible, and trusted response. These services, which have significant reach including into remote and isolated communities, have been largely provided as an "add-on" to mainstream services only when the latter had not effectively reached and responded to Māori. The Government has committed through the recent Budget 2022, to provide a funding increase to the Māori Provider Development Scheme to secure primary and community care innovation developed by Māori providers during COVID-19 and support this capability in the new health system. Budget 2022 also includes additional funding for a range of initiatives targeted at improving primary and community care responsive to Māori and supporting Māori led approach to population health and prevention.

96 Officials are also involved in regular engagement with iwi and Māori representatives to understand the impact changes may have on Māori and ensure good understanding of priorities. This also provides an opportunity to gain insight to how the Government can support what Māori consider is the best approach forward and improve systems for sharing information with Māori (and other communities) to enable stronger community-led health initiatives. This engagement will inform development of the targeted protections and Equity Impact Assessment proposed to be included as part of our new COVID-19 strategy.

Human rights

97 s9(2)(h) [redacted]

s9(2)(h)

98 s9(2)(h)

99 s9(2)(h)

100 s9(2)(h)

Consultation

101 This paper was prepared by the COVID-19 Group in DPMC. It has been informed by engagement with: Customs, Departments of Internal Affairs, Corrections, Ministries of Health, Education, Ethnic Communities, Foreign Affairs and Trade, Housing and Urban Development, Culture and Heritage, Social Development, Justice, Primary Industries, Business, Innovation and Employment, Transport, Pacific Peoples, Te Arawhiti, the Treasury, Te Puni Kōkiri, Oranga Tamariki, and the Public Service Commission, Health New Zealand, Office of Disability Issues, and the Māori Health Authority.

102 Engagement on the variant plan addressed the baseline and reserve measures approach and was covered in that paper [CAB-22-MIN-0223].

103 Officials discussed the strategy and the baseline and reserve approach with the Strategic COVID-19 Public Health Advisory Group, the Continuous Improvement Group, and the DPMC Community Panel prior to the development of this paper. Feedback included being clear on what 'resilient' means - individual, community, and/or system level. There was also concern that the strategy was missing the motivational, forward-looking aspects of a strategy – eg an aspiration for the best readiness systems. Surveillance and trusted data widely shared were highlighted as being extremely important to truly understanding the risks we face, particularly trends in community immunity levels. The community panel supported the availability of good information to assist communities to make their own judgement on risks. These concepts have been included in the baseline measures.

104 Members of the National Iwi Chairs Forum have agreed to work with officials on further engagement on the strategy and its impacts before the September consideration of the timing of moving to the new strategy.

Proactive release

105 This paper will be proactively released following Cabinet consideration.

Recommendations

The Minister for COVID-19 Response recommends that the Committee:

Strategy

1 note scenarios developed the World Health Organization, Department of the Prime Minister and Cabinet and the UK Health Security Agency show the most likely scenario is lessening severity of COVID-19 over time;

2 note we need a strategy to take us from post-winter 2022 towards managing COVID-19 like other diseases in the medium and long term;

3 agree to the high-level strategy of *prepared*, *protective, resilient, and stable* to replace the minimise and protect strategy currently in place (the timing for this change is covered in recommendations 12 and 13);

4 agree that, to give effect to the strategy, we will use an approach of relying on baseline measures, with more restrictive (reserve) measures kept in reserve for use in emergency circumstances to reduce COVID-19 transmission;

Baseline measures

5 note baseline measures are intended to be available at all times, can be dialled up and down depending on the risk presented by COVID-19 at the time, and seek to manage COVID-19 while having as little day-to-day impact on people and businesses as possible;

6 note that as severity of COVID-19 declines due to acquired immunity, vaccination, and the use of therapeutics, the best case scenario is that we expect to spend most of the time using baseline measures;

7 note protecting people and the health system will continue to underpin the prepared, protective and resilient, and stable strategy, with baseline measures building resilience (e.g. through vaccination campaigns) and both population and targeted protective);

Reserve measures

8 note that reserve measures are additional tools that can be used, with caution in emergency circumstances, to reduce COVID-19 transmission if an outbreak is likely to cause an unacceptable health impact on people and systems;

9 note that due to the uncertain nature of future COVID-19 variants, if or when reserve measures would be used cannot be determined in advance;

10 note that in June 2022, Cabinet agreed that in the event a new variant is detected that requires action, a lead-agencies response process would be triggered to develop system advice on the sequencing, thresholds for introduction, and combination of reserve measures considered desirable to respond to the variant [CAB-21-MIN-0223] and that, in addition to public health advice, the above system advice will give consideration to the non-health factors previously agreed by Cabinet [CAB-21-MIN-0421];

11 s9(2)(f)(iv) [redacted]

Repealing the COVID-19 Protection Framework and timing for moving to the new strategy

12 note that as we come out of winter 2022, it will be timely to consider whether the COVID-19 Protection Framework has served its purpose, given its design for Delta and Omicron, and whether we should move to the new strategy;

13 agree that the Minister for COVID-19 Response brings a paper to Cabinet in September 2022 addressing whether it is appropriate to revoke the COVID-19 Public Health Response (Protection Framework) Order 2021 and move to the new strategy;

14 s9(2)(h) [redacted]

Legislative settings

15 note that the COVID-19 Public Health Response Act 2020 will be automatically repealed in May 2023, if not sooner;

16 note the legislative framework for COVID-19 needs to shift from an emergency response-based framework, to ensure the right legislative powers and instruments are available to support our medium and longer-term management of COVID-19 and other infectious diseases;

17 note that some baseline measures may require empowering legislation to be implemented, and will need to be transitioned out of emergency legislation as soon as possible;

18 note if there are baseline measures that require legislative backing, which are not already being transitioned as part of agencies' own legislative work programmes, the Minister for COVID-19 Response proposes to introduce legislation to transition these measures, for enactment by December 2022;

19 note that most of the reserve measures will require empowering legislation to be implemented, and will need to be transitioned to a more enduring form of emergency legislation;

20 note if the Epidemic Preparedness (COVID-19) Notice 2020 expires before the legislation in recommendation 18 is enacted, the availability of baseline measures requiring legislative backing is not guaranteed because these measures would only be able to be used as they currently are within COVID-19 Orders to the extent that they have been authorised by the Prime Minister under section 8(c) of the COVID-19 Act;

21 note the Minister for COVID-19 Response intends to introduce legislation to transition the reserve measures to a more enduring emergency legislative framework, and ensure appropriate legislation is in place to temporarily respond to future pandemics while Parliament considers more enduring bespoke solutions, for enactment by May 2023;

22 note the Minister for COVID-19 Response will report back to Cabinet with more detailed proposals to support the transitions signalled in recommendations 17 and 19 in early August 2022;

Institutional settings

24 note that in December 2020, Cabinet agreed to establish a COVID-19 Response Unit with responsibility for coordination of cross-agency response activities and integration of advice; delivering the following functions [CBC-20-MIN-0100]:

24.1 strategy and policy integration;

24.2 system readiness and planning;

24.3 insights and reporting;

24.4 risk and assurance; and

24.5 communications and engagement;

25 note that as we transition to the next phase of our response, we need to ensure the COVID-19 system remains fit for purpose and well placed to deliver on the new COVID-19 strategy, and that the existing All-of-Government response system should be transitioned to a decentralised governance and operating model;

26 note that functions will not transition until the receiving agency is ready to take on those functions, including readiness to respond to a variant of concern;

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

28 agree to the proposed indicative transition plan for COVID-19 systems functions and governance as follows, noting that a process of due diligence will now be progressed to finalise timeframes and resources;

Existing DPMC COVID-19 Group functions	Host agency (tranche 1) August – December 2022	
nsights and reporting (including modelling)	Ministry of Health (Public Health Agency)	
Readiness and planning coordination	Ministry of Health	
Communications and engagement	Health NZ / Ministry of Health and border agencies	
Risk and assurance	Revert to accountable line agencies	
	Host agency (tranche 1) August – December 2022	**Host agency (tranche 2) January - June 2023**
Strategy and policy coordination	DPMC	DPMC or Ministry of Health

29 agree that with regard to the timing of the transfer of the All-of-Government strategy and policy coordination function, either:

29.1 Option 1: this be transferred from DPMC to the Ministry of Health no later than 31 December 2022

OR

29.2 Option 2: this be retained at DPMC, with functions transferred no later than 30 June 2023 [preference of the Minister for COVID-19 Response]

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

31 authorise the Prime Minister, the Minister of Finance, the Minister for COVID-19, and the Minister of Health, with Power to Act, to take decisions on the timing and associated appropriation changes (if any) resulting from the transition of the COVID-19 system outlined in this paper;

32 note the proposal to establish 'soft-wiring' mechanisms for a COVID-19 Senior Officials Committee and for Chief Executives to convene as required, and that the proposed Senior Officials Committee will not be formally constituted until the All-of-Government policy and strategy function transfers from the COVID-19 Group in the Department of the Prime Minister and Cabinet;

33 note that the National Response Leadership Team is no longer required to help guide the All-of-Government COVID-19 response;

34 agree to formally disestablish the National Response Leadership Team.

35 note that Public Sector Chief Executives have been cautioned that functions transferring from the COVID-19 Group may not transfer with the funding and costs may need to be absorbed by receiving agencies;

36 s9(2)(f)(iv) [redacted]

Authorised for lodgement

Hon Dr Ayesha Verrall

Minister for COVID-19 Response

Appendix 1

Cabinet Social Wellbeing Committee

Minute of Decision

COVID-19 Strategy for Post-Winter

Portfolio **COVID-19 Response**

On 29 June 2022, the Cabinet Social Wellbeing Committee:

Strategy

1 **noted** that scenarios developed by the World Health Organization, Department of the Prime Minister and Cabinet (DPMC), and the United Kingdom Health Security Agency show the most likely scenario is lessening severity of COVID-19 over time;

2 **noted** that a strategy is needed to take New Zealand from post-winter 2022 towards managing COVID-19 like other diseases in the medium and long term;

3 **agreed** to the high-level strategy of prepared, protective, resilient, and stable (the strategy) outlined in the paper under SWC-22-SUB-0118 to replace the minimise and protect strategy currently in place, with timing to be confirmed subject to the report backs in paragraph 13;

4 **agreed** that, to give effect to the strategy, an approach of relying on baseline measures will be used, with more restrictive (reserve) measures kept in reserve for use in emergency circumstances to reduce COVID-19 transmission;

Baseline measures

5 **noted** that baseline measures are intended to be available at all times, can be dialled up and down depending on the risk presented by COVID-19 at the time, and seek to manage COVID-19 while having as little day-to-day impact on people and businesses as possible;

6 **noted** that as severity of COVID-19 declines due to acquired immunity, vaccination, and the use of therapeutics, the best-case scenario is that New Zealand expects to spend most of the time using baseline;

7 **noted** that protecting people and the health system will continue to underpin the prepared, protective and resilient, and stable strategy, with baseline measures building resilience (e.g. through vaccination campaigns, and both population and targeted protection);

Reserve measures

8 **noted** that reserve measures are additional tools that can be used, with caution in emergency circumstances, to reduce COVID-19 transmission if an outbreak is likely to cause an unacceptable health impact on people and systems;

9 **noted** that due to the uncertain nature of future COVID-19 variants, if or when reserve measures would be used cannot be determined in advance;

10 **noted** that in June 2022, Cabinet agreed that in the event a new variant is detected that requires action, a lead-agencies response process would be triggered to develop system advice on the sequencing, thresholds for introduction, and combination of reserve measures considered desirable to respond to the variant and that, in addition to public health advice, the above system advice will give consideration to the non-health factors previously agreed by Cabinet [CAB-22-MIN-0223];

11 s9(2)(f)(iv) [redacted]

Repealing the COVID-19 Protection Framework and timing for moving to the new strategy

12 **noted** that as New Zealand comes out of winter 2022, it will be timely to consider whether the COVID-19 Protection Framework has served its purpose, given its design for Delta and Omicron, and whether it is timely to move to the new strategy;

13 **invited** the Minister for COVID-19 Response to report back to Cabinet in August 2022 to advise whether it is appropriate to revoke the COVID-19 Public Health Response (Protection Framework) Order 2021 and move to the new strategy;

14 s9(2)(h) [redacted]

Legislative settings

15 **noted** that the COVID-19 Public Health Response Act 2020 will be automatically repealed in May 2023, if not sooner;

16 **noted** that the legislative framework for COVID-19 needs to shift from an emergency response-based framework, to ensure the right legislative powers and instruments are available to support our medium and longer-term management of COVID-19 and other infectious diseases;

17 **noted** that some baseline measures may require empowering legislation to be implemented, and will need to be transitioned out of emergency legislation as soon as possible;

18 **noted** if there are baseline measures that require legislative backing, which are not already being transitioned as part of agencies' own legislative work programmes, the Minister for COVID-19 Response proposes to introduce legislation to transition these measures, for enactment by December 2022;

19 **noted** that most of the reserve measures will require empowering legislation to be implemented, and will need to be transitioned to a more enduring form of emergency legislation;

20 **noted** that if the Epidemic Preparedness (COVID-19) Notice 2020 expires before the legislation in paragraph 18 above is enacted, the availability of baseline measures requiring legislative backing is not guaranteed because these measures would only be able to be used as they currently are within COVID-19 Orders to the extent that they have been authorised by the Prime Minister under section 8(c) of the COVID-19 Act;

21 **noted** that the Minister for COVID-19 Response intends to introduce legislation to transition the reserve measures to a more enduring emergency legislative framework, and ensure appropriate legislation is in place to temporarily respond to future pandemics while Parliament considers more enduring bespoke solutions, for enactment by May 2023;

22 **noted** that the Minister for COVID-19 Response intends to report back to Cabinet in early August 2022 with more detailed proposals to support the transitions signalled in paragraphs 17 and 19;

Institutional settings

23 **noted** that in December 2020, the Cabinet Business Committee agreed to establish a COVID-19 Response Unit with responsibility for coordination of cross-agency response activities and integration of advice delivering the following functions:

23.1 strategy and policy integration;

23.2 system readiness and planning;

23.3 insights and reporting;

23.4 risk and assurance; and

23.5 communications and engagement;

[CBC-20-MIN-0100]

24 **noted** that, as New Zealand transitions to the next phase of the response, the COVID-19 system must remain fit for purpose and well placed to deliver on the new COVID-19 strategy, and that the existing All-of-Government response system should be transitioned to a decentralised governance and operating model;

25 **noted** that functions will not transition until the receiving agency is ready to take on those functions, including readiness to respond to a variant of concern;

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

27 **agreed** to the proposed indicative transition plan for COVID-19 systems functions and governance as follows, noting that a process of due diligence will be progressed to finalise timeframes and resources;

Existing DPMC COVID-19 Group functions	**Host agency (tranche 1) August – December 2022**	
Insights and reporting (including modelling)	Ministry of Health (Public Health Agency)	
Readiness and planning coordination	Ministry of Health	
Communications and engagement	Health NZ / Ministry of Health and border agencies	
Risk and assurance	Revert to accountable line agencies	
	Host agency (tranche 1) August – December 2022	**Host agency (tranche 2) January - June 2023**
Strategy and policy coordination	DPMC	DPMC

28 s9(2)(h) with functions transferred to the Ministry of Health no later than 30 June 2023;

29 s9(2)(g)(i)

30 **authorised** the Prime Minister, Minister of Finance, Minister of Health, and Minister for COVID-19 Response to take decisions on the timing and associated appropriation changes (if any) resulting from the transition of the COVID-19 system outlined in the paper under SWC-22-SUB-0118;

31 **noted** that:

31.1 it is proposed that 'soft-wiring' mechanisms be established for a COVID-19 Senior Officials Committee and for Chief Executives to convene as required;

31.2 the Senior Officials Committee will not be formally constituted until the All-of-Government policy and strategy function transfers from the COVID-19 Group in the Department of the Prime Minister and Cabinet;

32 **noted** that the National Response Leadership Team is no longer required to help guide the All-of-Government COVID-19 response;

33 **agreed** to formally disestablish the National Response Leadership Team;

34 **noted** that Public Sector Chief Executives have been cautioned that functions transferring from the COVID-19 Group may not transfer with the funding and costs may need to be absorbed by receiving agencies;

35 s9(2)(f)(iv)

Rachel Clarke
Committee Secretary

Present:
Hon Grant Robertson
Hon Kelvin Davis
Hon Chris Hipkins
Hon Carmel Sepuloni (Chair)
Hon Andrew Little
Hon Poto Williams
Hon Peeni Henare
Hon Kiri Allan
Hon Dr Ayesha Verrall
Hon Priyanca Radhakrishnan
Hon Aupito William Sio
Hon Meka Whaitiri

Officials present from:
Office of the Prime Minister
Office of the Chair
Officials Committee for SWC

CAB-22-MIN-0251

Cabinet

Minute of Decision

Report of the Cabinet Social Wellbeing Committee: Period Ended 1 July 2022

On 4 July 2022, Cabinet made the following decisions on the work of the Cabinet Social Wellbeing Committee for the period ended 1 July 2022:

[redacted]

[redacted]

SWC-22-MIN-0118 **COVID-19 Strategy for Post-Winter** CONFIRMED
Portfolio: COVID-19 Response

Rachel Hayward
Acting Secretary of the Cabinet