MINISTRY OF BUSINESS, INNOVATION & EMPLOYMENT
HĪKINA WHAKATUTUKI

COVERSHEET

Minister	Hon Dr Ayesha Verrall	**Portfolio**	COVID-19 Response
Title of Cabinet paper	New Zealand's future quarantine and isolation capability	**Date to be published**	31 July 2023

List of documents that have been proactively released		
Date	**Title**	**Author**
December 2022	New Zealand's future quarantine and isolation capability	Office of the Minister for COVID-19 Response
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Information redacted **YES**

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Some information has been withheld for the reasons of Confidentiality and Confidential advice to government.

In Confidence

Office of the Minister for COVID-19 Response

Cabinet Social Wellbeing Committee

New Zealand's future quarantine and isolation capability

Proposal

1 This paper seeks Cabinet's decision on a preferred option to retain and strengthen New Zealand's future quarantine and isolation capability beyond 30 June 2023, and agreement to transfer responsibility for progressing work back to the health system.

Relation to government priorities

2 This paper concerns two of the Government's priorities: continuing to keep New Zealanders safe from COVID-19, and laying foundations for the future.

Executive summary

3 Our experience with COVID-19 has highlighted the importance of being prepared and ready for future threats, and this decision presents an opportunity to prepare New Zealand well for that. We successfully stood up Managed Isolation and Quarantine (MIQ) as our core quarantine and isolation[1] response as part of the all-of-government response to COVID-19. Our responsibility is to now apply the lessons that we have learned, taking into account the information we know about the future, and prepare New Zealand's quarantine and isolation capability in the most effective way.

4 While the MIQ network was decommissioned in August 2022, the Ministry of Business, Innovation and Employment (MBIE) currently remains responsible for a) identifying opportunities to strengthen our future quarantine and isolation capability, and b) maintaining our operational readiness to re-establish MIQ (via a Readiness Plan, which has been developed for such purpose). MBIE funding for these activities ends on 30 June 2023.

5 MBIE has led the development of a programme business case (PBC) to identify options for retaining and strengthening our future quarantine and isolation capability, beyond 30 June 2023, to respond to future threats.

6 In April 2022, the former Minister for COVID-19 Response and the Ministers of Health and Finance approved the scope of a revised PBC to identify future isolation and quarantine capability opportunities. Cabinet and joint Ministers agreed to go back to a 'first principles' PBC canvassing a wider range of quarantine and isolation options, rather than focussing solely on developing

[1] For clarity, quarantine separates and restricts the movement of people who may have been exposed to an infectious disease while isolation separates people suspected or confirmed to be infected from other people who are not sick (and is therefore a higher risk population).

infrastructure solutions (such as purpose-built facilities) to constitute our future quarantine and isolation capability [SWC-22-MIN-0032 and MBIE briefing 2122-3105 refer].

7 The PBC considered three options, with each building upon the previous option:

7.1 Option one: Funding the continued maintenance, testing, and maturation of our existing Quarantine and Isolation Capability Readiness Plan (the Readiness Plan).

7.2 Option two: option one, plus development of a long-term quarantine and isolation capability strategy, and investment in an evolving portfolio of (contracted) self, community, and managed quarantine and isolation interventions. This is a significant step up from the current status quo and could include in its focus the case for facilities that have broad applicability for future events.

7.3 Option three: option two, plus investment in Crown-owned, purpose-designed quarantine and isolation facilities.

8 All options would provide up to 6,000 managed quarantine and isolation rooms, predominantly in hotel-based facilities to be made available when needed. Options two and three would also include provision for self and community-based quarantine and isolation. Option three would provide up to 1,500 additional managed quarantine and isolation rooms in purpose-designed facilities, designed to higher infection prevention control (IPC) and security specifications.

9 The PBC, MBIE, and health agencies support option two as a proportionate, cost effective and flexible package. I subsequently sought the views of the independent Strategic COVID-19 Public Health Advisory Group which highlighted the need to be ready and flexible in future to respond to new infectious disease threats, and supported greater investment into preparedness planning.

10 I recommend that we agree to progress option two, as this option thoroughly addresses New Zealand's preparedness for future events. If agreed, the evolving portfolio work under option two will have a particular focus on the case for facilities with broad applicability. In this way option two provides us with the greatest amount of flexibility and keeps 'all doors open' for future responses. I note that if we choose either option two or option three, work will be undertaken on a long-term strategy and exploratory work on emerging practices, services, and technology.

11 A decision on New Zealand's future pandemic preparedness is required now to ensure funding is secured, to provide enough time to negotiate new contractual retainers under the Readiness Plan Confidentiality [redacted] Agencies also need notice to prepare for

the service to be transferred back into the health system to ensure adequate transfer processes and procedures are in place.

12 Without funding, all activity on our future quarantine and isolation capability will cease on 30 June 2023. As a result, any future deployment of quarantine and isolation would be based on the previous MIQ model using a Readiness Plan that is no longer live (i.e. has no active contractual retainers, or institutional knowledge to support its execution).

13 I have explored a range of possible funding options and recommend that Cabinet agree to transfer a portion of the forecast MBIE MIQ underspend to progress option two, which would cost $7.4 million over two years.

14 I recommend that responsibility for progressing any option be transferred from MBIE back to the health system by 30 June 2023. Quarantine and isolation are, fundamentally, public health interventions. I believe that this work should sit across Manatū Hauora, Te Whatu Ora, and Te Aka Whai Ora.

Background

MIQ was developed at pace to respond to COVID-19

15 As part of a multi-layered response, MIQ was essential to our pursuit of eliminating COVID-19, while allowing our borders to remain porous, because arrivals could be managed in such a way that reduced the risk of importation and widespread transmission of COVID-19. In this way, MIQ enabled people to travel to New Zealand when our border would have otherwise had to remain closed.

16 Between April 2020 and June 2022, approximately 230,000 border arrivals and 5,000 community cases (and their close contacts) went through MIQ.

17 MIQ also bought us time to vaccinate over 90 percent of eligible New Zealanders,[2] and for antivirals to be developed and made available. MIQ undeniably helped save lives.

18 MIQ provided a means for people to return home in a safe, managed way, however, its limited capacity caused significant stress for people who could not return when they wanted.

19 Demand for MIQ declined significantly in early 2022 due to the roll-out of self-quarantine and self-isolation for border arrivals under Reconnecting New Zealand. Consequently, in April 2022, the former Minister for COVID-19 Response, in consultation with the Prime Minister and the Minister of Health, agreed to decommission the MIQ network in its entirety by August 2022.

[2]Over 90 percent of eligible New Zealanders aged 12+ had completed a primary course of COVID-19 vaccinations by the time MIQ was decommissioned in August 2022.

Future pandemics may require a strong public health response that can respond to a range of scenarios

20 Quarantine and isolation capability may be critical components of our public health response to any new infectious disease threat. Consistent with the PBC's analysis, the Strategic COVID-19 Public Health Advisory Group (SPHAG) advises that the frequency of disease threats is likely to increase and may rapidly spread to and throughout New Zealand. While the timing of future events is unknown, there is a good understanding of the kind of diseases that could require quarantine and isolation capability.

21 Our future quarantine and isolation capabilities could have a role beyond epidemic or pandemic settings, in localised and/or domestic outbreaks (e.g. measles) to break chains of transmission early or, if facilities are agreed to in the future, used to assist with threats of a different nature (e.g. housing people following a natural disaster or mass arrivals).

22 A quarantine and isolation capability that can respond to a range of pathogens and threats and can manage different cohorts according to their risk will be the most thorough approach.

A Readiness Plan is in place to reactivate MIQ, if necessary

23 MBIE developed the Readiness Plan, a comprehensive plan for rapidly re-establishing managed quarantine and isolation capability based on the MIQ model, if necessary. This has been developed with support from other agencies.

24 The core components of the Readiness Plan include contractual retainers with former MIQ hotels in Auckland and Christchurch and key suppliers previously involved in the delivery of MIQ; a guide for standing up quarantine and isolation in (and relating to) these hotels; and the ability to have 1,500 quarantine and isolation rooms operational within 3-4 weeks, surging to 3,000 rooms within six weeks, and 6,000 rooms within 8 weeks[3].

25 The Readiness Plan is also currently supplemented by Te Whatu Ora, COVID-19 Care in the Community, a multi-agency response to support individuals to self-isolate and quarantine in their own communities. Funding for Care in the Community is currently scheduled to end in December 2022.

26 The Readiness Plan is only funded to 30 June 2023. It requires regular updating to ensure it remains current, fit-for-purpose and ready to use. If activated, significant new funding and an all-of-government response would be required to rapidly re-establish quarantine and isolation capacity.

[3]Contractual retainers are in place for 1,500 rooms across eight hotels in Auckland and Christchurch. Whilst retainers are not in place for the additional 4,500 rooms, MBIE is confident that they could be procured if border restrictions were in place (and potential facilities were therefore unoccupied).

A Programme Business Case supports investment in retaining and strengthening our future isolation and quarantine capability

27 In April 2022, the former Minister for COVID-19 Response and the Ministers of Health and Finance approved the scope of a revised PBC to identify future isolation and quarantine capability opportunities. Cabinet and joint Ministers agreed to go back to a 'first principles' PBC canvassing a wider range of quarantine and isolation options, rather than focussing solely on developing infrastructure solutions (such as purpose-built facilities) to constitute our future quarantine and isolation capability [SWC-22-MIN-0032 and MBIE briefing 2122-3105 refer].

28 MBIE engaged external consultants in preparing the PBC. Iwi that had MIQ facilities in their rohe, government agencies, SPHAG, Te Waihanga (the New Zealand Infrastructure Commission), and private sector partners (from airlines, airports, hotels, and transport) were consulted in its development.

The PBC considered three options

29 The final PBC (see Appendix 1) considered options for retaining and strengthening our future quarantine and isolation capability:

Option one

29.1 Fund the continued maintenance, testing, and maturation of our existing Readiness Plan[4].

Option two (preferred by the PBC and recommended by the Minister for Covid-19 Response)

29.2 Option one, plus

29.3 Development of a long-term quarantine and isolation capability strategy, and

29.4 Investment in an evolving portfolio of (contracted) self, community, and managed quarantine and isolation interventions including an analysis of opportunities for future facilities with wide applicability.

Option three

29.5 Option two, plus

29.6 Investment in Crown-owned, purpose-designed quarantine and isolation facilities.

30 I recommend that we support option two, as this option will position us with the best flexibility to respond to future infectious disease and other threats. I will outline the options in more detail to facilitate Cabinet's decision making.

[4] The PBC assumed that Care in the Community (CitC) would support people to self-quarantine or self-isolate, if required.

Option one 'keeps warm' our current approach

31 Continuing to fund the Readiness Plan in the short-term would ensure that we are operationally ready to rapidly re-establish managed quarantine and isolation at the border, to respond to either a COVID-19 variant of concern, or other human infectious disease.

32 It would provide up to 6,000 managed quarantine and isolation rooms in hotel-based facilities.[5]

33 The direct cost of progressing option one would be less costly than options two and three and may be more proportionate as insurance against large-scale future events which may not eventuate for some time.

34 However, pursuing option one would mean that we limit our response capability to large-scale future events and essentially 'keep warm' our previous response rather than working to future-proof our capability based on lessons learned (reflected in the findings of the Grounded Kiwis judicial review, Ombudsman investigations, or an inquiry into our future pandemic preparedness), international developments, technological advancements, and improvements in our understanding of human infectious disease threats.

Option two is supported by the PBC as it would balance potential costs, benefits, and risks without limiting our future options

35 Option two was developed in response to the Cabinet and joint Ministers' decision to do a 'first principles' review and is the preferred option highlighted by the PBC. The PBC recommended option two on the basis that it renders New Zealand strategically prepared and operationally ready to deploy quarantine and isolation in a manner conducive to the achievement of equitable health outcomes, and best balances the potential costs, benefits, and risks (such as possessing expensive facilities that may have limited utility) without limiting our future options.

36 Option two is comprised of three components – one of which is option one, and two of which are additional – *a long-term quarantine and isolation capability strategy* and related investment in an *evolving portfolio of interventions* (e.g. services and facilities in which people can isolate or quarantine within their communities, and/or procuring facilities that could be used for health services in the future).[6]

37 *The development of a long-term strategy* would concern disease outbreaks, epidemics, and pandemics. It would set the direction for developing and

[5]At its height, MIQ had approximately 6,000 rooms. MBIE is confident that the same number of rooms could be procured under the Readiness Plan or the evolving portfolio (which would supersede the Readiness Plan). Whilst it may be possible to procure more than 6,000 rooms, officials have not conducted market soundings to test this possibility (to avoid pre-empting Cabinet's decisions on New Zealand's future quarantine and isolation capability).

[6] The evolving portfolio is essentially a range of different contracted initiatives that come together to form a coherent, flexible, and well-considered investment programme are designed to that meet needs. Because the initiatives are contracted, we do not become tied to a specific portfolio.

deploying risk-based quarantine and isolation interventions, within the context of wider response systems, strategies, and plans.

38 Having a strategy of this nature would enable us to anticipate, prepare for, and act on a wide range of future scenarios (both at the border and in the community), and have a strong basis for investment in our future quarantine and isolation capabilities (under the evolving portfolio).

39 *Investment in an evolving portfolio of interventions* would provide us with a wider range of interventions over time than what is available under the Readiness Plan, including more diversified regional coverage[7]. In this context, 'interventions' includes (contracted) facilities, services, technology, and related systems that take advantage of knowledge gain and market opportunities to develop and enhance IPC design, service models, logistics, technologies and workforce arrangements and which operate both as part of an all-of-government response and in a targeted way to address threats and outbreaks. Suboptimal or surplus arrangements would be offloaded from the portfolio under this contracting model. Investment in and effective use of emerging technology, for example, may reduce demands on workforce in a response and facilitate better and faster information-sharing and analytics to allow the deployment of a risk-based and equitable approach to intervention.

40 Confidential advice to Government .

41 Together, these interventions would form an 'evolving portfolio' of quarantine and isolation interventions that would evolve over time in relation to our then-current needs and the effectiveness of those interventions.

42 The evolving portfolio, in combination with the future quarantine and isolation capability strategy, would supersede the Readiness Plan. The strategy would ensure we are strategically prepared to respond to various scenarios, whilst the evolving portfolio would ensure we are operationally ready to deploy a range of quarantine and isolation interventions.

43 For clarity, the evolving portfolio would comprise quarantine and isolation interventions that are contracted by the Crown, or involve co-investment with other entities (e.g. Iwi, commercial, or community groups).

44 The evolving portfolio could involve:

44.1 Managed quarantine and isolation interventions: contracting a range of facilities, procuring facilities that could be used for health services or small-scale outbreaks in 'peacetime', ensuring greater geographic spread of facilities across the country, and investing in targeted design;

44.2 Community-based quarantine and isolation interventions: contracting or co-investing in a range of facilities or accommodation in which people

[7] While retaining contracts with existing suppliers to service the border is sensible under the Readiness Plan, the PBC supports investment in a wider range of interventions across regions.

can quarantine or isolate within their communities, and investing in wraparound community-based quarantine and isolation, particularly for priority populations (Māori and Pacific peoples)[8]; and

44.3 Self-quarantine and self-isolation interventions: investing in services to support large-scale self-quarantine and self-isolation, and technology to inform, educate, support, and monitor people under self-quarantine or self-isolation[9].

45 Investing in an evolving portfolio provides a useful opportunity to design and procure quarantine and isolation interventions that are more effective, flexible, and equitable in their design. In particular, under the evolving portfolio procuring flexible arrangements would negate against over-investment (eg in facilities where capacity can only be scaled up, rather than up or down depending on context), and ensure that our capabilities remain consistent with best practice, leverage the latest available technologies, and evolve according to emerging public health threats.

46 On balance, the PBC and health agencies consider that option two offered the best proposition when all costs, benefits and risks were considered, does not preclude pursuing bespoke facilities should they be required, and does not involve the Crown developing significant fixed assets.

Option three invests in Crown-owned, purpose-designed facilities

47 Option three also provides us with flexibility to respond to future infectious disease threats. This is achieved through the components of option two with investigation of additional Crown-owned managed quarantine and isolation rooms beginning now and then proceeding beyond business case stage after an inquiry into the Government's COVID-19 response.

48 The PBC considered the case for investment in Crown-owned, purpose-designed[10] quarantine and isolation facilities, and identified several benefits of this approach:

48.1 Assured access to up to 1,500 additional managed quarantine and isolation rooms, and a dedicated, trained workforce operating in a known environment;

48.2 economic and social benefits in potentially reducing the need for, duration and severity of lockdowns through effective containment and interruption of transmission if able to be used in a timely[11] and targeted manner;

[8] This is currently a service provided by health agencies until the end of this calendar year.
[9] Te Whatu Ora have agreed to take ownership of the self-quarantine plan.
[10] Purpose-designed facilities could involve new builds, or upgrades to existing buildings.
[11] A DBC would estimate how timely facilities could be stood up in a response, as it will depend on the size, location, and operating model of the facility.

48.3 Design of the additional rooms to higher IPC and security standards resulting in reduced risk of in-facility transmission, resulting in wellbeing and equity benefits for workforces and users;

48.4 Benefit at the beginning of certain domestic outbreaks (to interrupt transmission), or where little is known about the health status of cohorts arriving from jurisdictions with high infectious disease risk; and

48.5 Using facilities as live environments for research and training purposes, testing of processes and equipment, and piloting developments in IPC protocols, services and technology when they are not otherwise required, and wider public value through alternative/compatible uses.[12]

49 Purpose-designed facilities could not eliminate the risk of community transmission absolutely.

50 I also note that it would take between five to eight years to establish these facilities.

51 Investing in Crown-owned, purpose-designed quarantine and isolation facilities also presents significant costs (both fiscal and opportunity), and risks. The quarantine and isolation gains, therefore, need to be weighed against:

51.1 the high cost of these facilities (to build, refit and maintain them), and how that money could be otherwise prioritised to respond to infectious disease threats;

51.2 the significant risks in terms of construction, supply chain and workforce issues, and the risk that as fixed assets they may ultimately not be fit for purpose or used and cannot easily be offloaded in the same way as contracted arrangements; and

51.3 the marginal additional capacity (up to 1,500 rooms) that purpose-designed facilities would offer within a large-scale response.

52 The health system is currently undergoing a once in a generation reform. At the same time, it is facing operational pressures, and has competing priorities and cost pressures. Health officials do not currently consider investing in Crown-owned purpose-designed quarantine and isolation facilities would be the best value for money in terms of health gain compared to other potential expenditure options. In particular, health agencies consider that investment in infectious disease preparedness and response would be best targeted at services to reduce existing inequity issues. Option two is the preferred option for Health agencies[13].

[12] These would be further explored in a DBC if Cabinet agrees.
[13] I am advised that the Te Whatu Ora Board has not yet considered the detailed proposals canvassed in this paper.

53 The Strategic COVID-19 Public Health Advisory Group indicated that broad consideration should be given to our future response, as there are different roles that the health and private sectors could play, and a range of infrastructure solutions.

54 The PBC concluded that, on balance, its objectives could be met through the less costly and less risky option two.

55 I note that considerable work was undertaken on alternative uses of facilities until the scope of the PBC was broadened. The earlier work explored whether (new or existing) facilities could be:

55.1 used for quarantine and isolation, with alternative uses during 'peacetime'; or

55.2 used for other primary functions, with quarantine and isolation as the alternative use when needed.

56 However, work would need to be completed to confirm the viability of any alternative/compatible use. A viable alternative/compatible use for purpose-designed facilities would mitigate the costs and risk or redundancy of option three and would generate wider public value. However, there is no firm conclusion at this stage about the viability of alternative uses. I note that under my recommended option, option two, an analysis into how broadly facilities could be utilised is proposed. This analysis would give us a better steer on whether investments via a detailed business case (DBC) are warranted.

57 Regardless of the option we decide to progress now, there are a range of choices to be made in the future about the shape and extent of investment. For example, Cabinet will need to take several funding decisions in the future to give full effect to option two (e.g. to invest in quarantine and isolation interventions under the evolving portfolio) or option three (e.g. to invest in purpose-designed facilities).

Progressing an option requires further work to June 2025

Work programme for option one

58 Progressing option one now would require new contractual retainers to be negotiated with providers prior to 30 June 2023 so that there is a timely transition from the MBIE-held contracts.

Work programme for option two

59 Progressing option two would further require developing a future quarantine and isolation capability strategy and developing initial investment proposals for an evolving portfolio of self, community, and managed quarantine and isolation interventions.

60 If we decide to progress option two, I recommend that we direct officials to provide Cabinet with a draft quarantine and isolation capability strategy and

initial investment proposals for the evolving portfolio in November 2023. The initial proposals for the evolving portfolio should include, as the priority focus, Confidential advice to Government new human infectious disease events). Note that if work on facilities is agreed to on the basis of this analysis, a DBC will be required for any future capital investment.

61 To be clear, funding for procuring any quarantine and isolation interventions under the evolving portfolio would need to be sought separately Confidential advice to Government Confidential advice to Government

Work programme for option three

62 In addition to option two, progressing option three would require developing a DBC to investigate investment in Crown-owned, purpose-designed quarantine and isolation facilities. Confidential advice to Government

63 Most DBCs of this nature take around one year to develop. The actual timeframe for developing a DBC would depend on the parameters we provided to officials.

64 If we agree to progress option three, I recommend that a DBC only be developed once an inquiry into the Government's COVID-19 response is complete (currently scheduled to be mid-2024). Commencing the development of a DBC in advance of an inquiry may result in recommendations that do not reflect, or take full account of, any relevant findings.

65 To be clear, funding for developing the DBC and establishing Crown-owned, purpose-designed quarantine and isolation facilities Confidential advice to Confidential advice to Government .

Financial implications

66 The Isolation and Quarantine Management Appropriation within Vote Building and Construction, under which MBIE's remaining quarantine and isolation activities are conducted, ends on 30 June 2023. Te Whatu Ora Care in the Community funding ends December 2022.

67 There is estimated to be a $22 million underspend in this appropriation due to staff finding new employment opportunities (within MBIE and elsewhere), reducing redundancy and other costs associated with downsizing MIQ (the final underspend amount is dependent on future decision making regarding residual debt and redundancy). If we agree to fund any of the options, we could reprioritise a portion of this underspend to health agencies to fund isolation and quarantine activities for Financial Years 2023/24 and 2024/25. The remaining underspend would be returned to the Crown.

68 The financial implications of each option are set out below.

Progressing option one now would cost approximately $4.5 million to June 2025

69 The cost breakdown per fiscal year from July 2023 to June 2025 for option one is as follows:

Option one	**Cost ($m)**
Hotel retainers	Confidentiality
Security retainers	
Transport retainers	
IT retainers	
Iwi expertise	
Aviation Security Service training	
Legal costs	
Confidentiality	
Total per annum	**2.256**

70 Confidentiality .

71 Activating the Readiness Plan (surging to up to 6,000 managed quarantine and isolation rooms) would require significant new funding. The PBC estimates that this cost would be between $600m and $800m per annum[15].

Progressing option two would cost approximately $7.4 million to June 2025

72 The cost breakdown per fiscal year from July 2023 to June 2025 for option two is as follows:

Option two	**Cost ($m)**
Option one	2.256
Confidentiality	Confidentiality

[14] Confidentiality

[15] The PBC's estimates of annual operating cost at full capacity exclude the cost of any frontline workers (seconded) from government agencies.

Confidentiality	Confidentiality
Total per annum	**3.679**

73 Confidentiality .

74 However, as MBIE is currently responsible for border related isolation and quarantine capability (as opposed to community related capability), MBIE's transfer of functions would be reliant on existing health system functions and expertise to continue to support community related isolation and quarantine.[16]

75 Confidential advice to Government

76 The PBC estimates that the ongoing annual running cost of option two during 'peacetime' would be between $10.9 million and $13.5 million per annum Confidentiality, to develop and deliver the work programme, and to establish and manage contracts under the evolving portfolio), and at full capacity (surging to up to 6,000 managed quarantine and isolation rooms, plus rolling out services, facilities, technology, and/or related systems for self and/or community-based quarantine and isolation) between $600 and $800 million per annum (being indicative annual operating costs of the portfolio in response to a pandemic on the scale of COVID-19).

Progressing option three would cost approximately $12.4 million to June 2025

77 Progressing option three now would cost approximately $3.7 million per fiscal year from July 2023 to June 2025 (the same as option two). However, under option three, additional funding is sought in FY 2024/25 to cover the costs of a DBC.

78 The cost breakdown from July 2023 to June 2025 for option three is as follows:

Option three	**Cost ($m)**
Option two (per fiscal year)	3.679
DBC undertaken after the completion of an inquiry (onetime cost)	5.000
Total cost	**12.358**

[16] While health agencies used MBIE's border facilities to manage community cases in some instances, community cases have predominantly been a health managed capability.

79 The PBC estimates that the ongoing running cost of option three during 'peacetime' would be between $20.1 million and $32.1 million per annum Confidentiality to develop and deliver the work programme, to establish and manage contracts under the evolving portfolio, and to maintain and operate Crown-owned facilities), and at full capacity (surging to up to 7,500 managed quarantine and isolation rooms, plus rolling out services and/or facilities for self and/or community-based quarantine and isolation) between $800 million and $1 billion per annum (being indicative annual operating costs of the portfolio in response to a pandemic on the scale of COVID-19).

80 In any event, the PBC estimates that the capital cost of constructing up to three Crown-owned, purpose-designed facilities could be between $154 million and $1.17 billion.[17]

81 For comparison, MIQ cost $781 million to operate in FY 2020/21, and $788 million to operate in FY 2021/22. These figures, like the PBC estimates, exclude the cost of frontline workers from government agencies (e.g. former District Health Boards, NZDF, New Zealand Police), which were funded from agency baselines.

Funding for two years is required now to progress either option one, two, or three

82 Funding to progress an option is required now. Confidential advice to Government .

83 Waiting to secure funding risks leaving insufficient time to negotiate new contractual retainers under the Readiness Plan (which end on 30 June 2023) Confidentiality . Securing two years of funding provides further certainty for providers, and for government.

84 Confidential advice to Government The initial components of the evolving portfolio could then take up to a year to build. Capital investment in future facilities with wide applicability will require a DBC, Confidential advice to Government . Funding the Readiness Plan to June 2025 would ensure that, whilst the evolving portfolio is being built, we remain operationally ready to rapidly re-establish quarantine and isolation.

[17] The significant range in cost estimates for option three is due to the wide range of rooms that the PBC considered could be established across one to three Crown-owned, purpose-designed facilities (between 250 and 1,500 rooms), and the contingency applied to cost estimates (due to the inherent risks associated with construction projects of this nature).

If funding is not secured, all activity will cease on 30 June 2023

85 If funding is not secured beyond 30 June 2023, I anticipate that all activity on retaining and strengthening our future quarantine and isolation capability will cease on that date (including the Readiness Plan).

86 As a result, any future deployment of quarantine and isolation would likely need to be based on the MIQ model, using a Readiness Plan that is no longer live (i.e. has no contractual retainers with providers, or institutional knowledge and expertise to support its execution).

87 Solely relying on MIQ's previous model poses significant risks:

87.1 The public will expect future governments to be better prepared and ready to respond to similar events in the future, having learned from MIQ's operation. Failure to demonstrate this capability may reduce public trust and confidence, and therefore impinge on social license to institute various response measures.

87.2 We may not have the right mix of people or skills at our disposal to re-establish an operation like MIQ, at pace, and no certainty as to our ability to secure a sufficient private security workforce, and the NZDF may otherwise be engaged.

87.3 We may not be up to speed with, or able to access, critical technological developments. In turn, we may rely more heavily on the health workforce, placing greater pressure on the health system. Our lessons learnt and recommendations highlight this risk.

87.4 We would be reliant on what is effectively a 'one size fits all' model, which may contribute to perpetuating health inequities among, for example, Māori, Pacific peoples, and disabled people.

Responsibility for quarantine and isolation should transfer from MBIE back to the health system by 30 June 2023

88 In June 2020, Cabinet agreed that, for the purpose of our COVID-19 response, MBIE would assume the role of lead agency for the provision of MIQ [CAB-20-MIN-0284 refers].

89 Whilst MBIE has developed significant expertise throughout the delivery of MIQ, the design and delivery of isolation and quarantine capability is not part of MBIE's core business. MBIE's expertise is also declining with staff attrition.

90 Officials consider that responsibility for progressing work to retain and strengthen our future quarantine and isolation capability best sits within the health system, because quarantine and isolation are, fundamentally, public health interventions (noting that prior to COVID-19, the health system was responsible for quarantine and isolation).It is imperative that our future

isolation and quarantine capability is integrated with relevant public health functions (e.g. international health monitoring and reporting) and aligned with broader health plans (e.g. a strategic approach to health at the border being developed by Manatū Hauora).

91 To that end, I recommend that responsibility for progressing work on retaining and strengthening our future quarantine and isolation capability be transferred from MBIE back to the health system no later than 30 June 2023.

92 This timeframe will provide for a well-considered and orderly transfer, given that the health system is still bedding-in its most significant change in a generation, and any transfer of responsibility will need to be carefully planned to ensure continuity and certainty. It also aligns with the end date for transfer of DPMC's COVID-19 Group functions.

93 Certain components of whichever option we agree are likely to best sit across different parts of the health system – principally, the Public Health Agency within Manatū Hauora (strategy and policy), Te Whatu Ora (service design and delivery) and Te Aka Whai Ora.

94 In preparation for this transfer of responsibility, I recommend that we direct MBIE, Manatū Hauora, and Te Whatu Ora to provide myself, the Minister of Health, and the Minister of Finance with a detailed transition roadmap in March 2023. This roadmap should outline where in the health system responsibility for each component of our agreed option will transfer to, and by when. These agencies are already working collaboratively on this roadmap. Of course, the scope of the transfer will depend on the option we agree to.

Agreement is needed to transfer funding from MBIE to the health system

95 Funding to progress any work on option one, two, or three will also need to be transferred from MBIE to the relevant parts of the health system. I expect that Confidentiality

96 The 2022/23 Isolation and Quarantine Management multi-category appropriation within Vote Building and Construction was funded from the COVID-19 Response and Recovery Fund. Funding within this appropriation is currently ring-fenced to MIQ and cannot be transferred to other appropriations. Once MIQ winds down any remaining funding is to be returned to the Crown [CAB-20-MIN-0511 refers]. As noted, we estimate a $22 million underspend that may be available to return to the Crown.

97 I recommend that we agree to slightly relax the restriction on transfers of existing funding from the Isolation and Quarantine Management multi-category appropriation to other appropriations, such that a transfer could take place from Vote Building and Construction to Vote Health.

98 I recommend we transfer a portion of the 2022/23 Isolation and Quarantine Management multi-category appropriation underspend to progress work beyond 30 June 2023.

Legislative implications

99 There are no legislative implications arising from this paper's proposals.

Regulatory Impact Statement

100 A Regulatory Impact Statement is not required as there are no legislative implications arising from this paper's proposals.

Human rights implications

101 Quarantine and isolation can limit several rights and freedoms under the New Zealand Bill of Rights Act 1990. These include the rights to freedom of movement, freedom from unreasonable search and seizure, and to not be arbitrarily detained.

102 A long-term quarantine and isolation capability strategy would provide a framework for decisions brought to bear on human rights (eg by setting out the various scenarios under which different quarantine and isolation options would be deployed).

103 Having a range of quarantine and isolation facilities and services (including provision for supporting self-quarantine and self-isolation) would preserve our ability to actually deploy different options in a way that is proportionate to risk.

Population Implications

104 The health, economic, and social impacts of human infectious disease threats are not experienced equitably. People with underlying health conditions, people who are unable to safely quarantine or isolate (eg due to insufficient housing, or inaccessible facilities), and people who have traditionally been under-served by health and social sectors are at particular risk.

105 In New Zealand, Māori, Pacific peoples, older, and disabled people are more likely to experience inequitable health, economic, and social outcomes associated with human infectious disease threats, and our responses to them.

106 Quarantine and isolation have proven to be critical public health interventions for preventing, minimising, and managing certain human infectious disease threats. To that extent, retaining our quarantine and isolation capability will contribute to mitigating the risk that human infectious disease threats pose to certain communities.

107 However, we know that quarantine and isolation have potential to contribute to the perpetuation of inequities – by having facilities located in certain geographic areas (which either heightens risk of disease leakage to local communities, or denies other communities access to them), by heightening psychosocial stress, or by failing to provide culturally-appropriate care.

108 Investing in the strengthening of our future quarantine and isolation capability provides opportunities to mitigate potential harms, and institute measures more conducive to the achievement of equitable outcomes. For example, procuring an evolving portfolio will involve engaging with the aforementioned communities to explore more innovative and acceptable ways of delivering quarantine and isolation.

Treaty of Waitangi Analysis

109 I expect work on retaining and strengthening our future quarantine and isolation capability to give effect to the guarantee of tino rangatiratanga and obligation of partnership, in both its development and delivery.

110 The creation of an evolving portfolio of quarantine and isolation interventions provides opportunity to give effect to the Crown's obligation to provide options. The evolving portfolio could comprise options that are consistent with relevant tikanga, grounded in hauora Māori models of care, and delivered by kaupapa Māori providers – should such options be deemed appropriate to Māori.

111 Retaining and strengthening our future quarantine and isolation capability should give effect to the Crown's obligation of active protection, and commitment to achieving equitable health outcomes. The long-term quarantine and isolation capability strategy will set out how quarantine and isolation capability will be used to achieve such end (eg by prioritising access to specific facilities or services in certain communities).

Consultation

112 This paper was prepared by MBIE. The following agencies were consulted: Manatū Hauora, Te Whatu Ora, Te Aka Whai Ora, The Treasury, DPMC, NZDF, NEMA, the Public Service Commission, the New Zealand Customs Service, the Ministry for Housing and Urban Development, the Ministry for Social Development, Te Puni Kōkiri, the Ministry for Pacific Peoples, Whaikaha, Te Waihanga.

113 The following groups were consulted on the development of the PBC: Iwi that had MIQ facilities in their rohe, SPHAG, and private sector partners (from airlines, airports, hotels, and transport services).

Treasury comment

114 The Treasury does not support option three on the basis that purpose-designed facilities would carry significant fiscal costs and risks, for uncertain marginal benefit over the other options. Purpose-built facilities would have a sizeable upfront cost and a significant opportunity cost from sitting empty when not needed to respond to an outbreak if a suitable alternative use could not be found. Option three also carries significant delivery risks, given constrained construction capacity.

115 Given that the DBC for option three is proposed to commence in late 2024, funding for the DBC is not urgently required and Confidential advice to Government

116 For any option, the Treasury does not support taking the decision to reprioritise funding for continuing isolation and quarantine activities now. We would expect to see further information on where in the health system this function would sit before reprioritisation is agreed, such that the necessary funding and FTE for this function could be better assessed and justified. As such, we recommend that Cabinet delegates authority for the Minister of COVID-19 Response, Minister of Health, and Minister of Finance to reprioritise funding from the Isolation and Quarantine Management Multi-Category Appropriation when the detailed roadmap for the transfer of responsibility from MBIE back to the health system is considered in March 2023.

I have considered this advice, but recommend that we seek funding for option two now

117 I note that accepting this advice will have significant impacts on MBIE's staff who will not have certainty on whether they can transfer to the health system until March 2023. This uncertainty will be unsettling for some staff, who may choose to secure roles outside of this work in anticipation that funding is not secured.

118 Further, funding the option we choose now, rather than after the completion of a roadmap detailing the transfer of functions to the health system, is important to ensure a smooth transition and that current staff have clarity of their future roles beyond June 2023.

Communications

119 A communications plan will be developed consistent with Cabinet's direction.

Proactive Release

120 This paper will be proactively released within the standard 30 business days of decisions being made by Cabinet, with appropriate redactions where information would have been withheld under the Official Information Act 1982.

Recommendations

The Minister for COVID-19 Response recommends Cabinet:

1 **Note** that the Ministry of Business, Innovation and Employment (MBIE) currently remains responsible for identifying opportunities to strengthen our future quarantine and isolation capability, and maintaining our operational readiness to re-establish MIQ (via the Readiness Plan);

2 **Note** that the Isolation and Quarantine Management Appropriation within Vote Building and Construction, under which MBIE's remaining quarantine and isolation activities are conducted, ends on 30 June 2023;

3 **Note** that this funding is currently ring-fenced to MIQ and cannot be transferred to other appropriations, and that once MIQ winds down any remaining funding is to be returned to the Crown [CAB-20-MIN-0511 refers];

4 **Note** that MBIE currently estimates a $22 million underspend in this appropriation, which will be returned to the Crown in June 2023, barring any Cabinet decisions to reprioritise this underspend;

5 **Note** that a programme business case (PBC) has considered three options for retaining and strengthening our future quarantine and isolation capability, beyond 30 June 2023;

6 **Agree** to progress either:

6.1 Option one: Funding the continued maintenance, testing, and maturation of our existing Readiness Plan;

OR

6.2 Option two: Option one, plus development of a long-term quarantine and isolation capability strategy, and investment in an evolving portfolio of (contracted) self, community, and managed quarantine and isolation interventions (the Minister for COVID-19 Response's preferred option and the PBC preferred option);

OR

6.3 Option three: Option two, plus investigation into in Crown-owned, purpose-designed quarantine and isolation facilities;

7 **Note** that if new funding is not secured to progress any of the options, I anticipate that all activity on retaining and strengthening New Zealand's quarantine and isolation capability will cease on 30 June 2023;

If option one is agreed to

8 **Agree** to provide funding of $2.6 million per annum from July 2023 to June 2025 to progress option one;

9 **Note** that the PBC estimates that the annual cost of activating the Readiness Plan at full capacity would be between $600m and $800m per annum;

If option two is agreed to

10 **Agree** to provide funding of $3.7 million per annum from July 2023 to June 2025 to progress option two (or three);

11 **Direct** officials to provide Cabinet with a draft long-term quarantine and isolation capability strategy by November 2023;

12 **Direct** officials to provide Cabinet with initial investment proposals for an evolving portfolio of self, community, and managed quarantine and isolation interventions by November 2023;

13 **Note** that, Confidential advice to Government

14 **Note** that agreement to future capital investment based on the analysis in recommendation 13, will require a detailed business case;

15 **Note** that the PBC estimates that the ongoing annual running cost of option two during 'peacetime' would be between $10.9 million and $13.5 million per annum, and at full capacity between $600 and $800 million per annum. The Confidential advice to Government

Additionally, on top of option two recommendations, if option three is agreed to

16 **Agree** to provide funding of $5.0 million in 2024/25 for the development of a detailed business case investigating investment in Crown-owned, purpose-designed quarantine and isolation facilities, to commence once an inquiry into New Zealand's preparedness for a future pandemic is complete;

17 **Note** that the PBC estimates that the capital cost of constructing up to three Crown-owned, purpose-designed facilities (yielding up to 1,500 quarantine and isolation rooms) could be between $154 million and $1.17 billion. This Confidential advice to Government

18 **Note** that the PBC estimates that the ongoing annual running cost of option three during 'peacetime' would be between $20.1 million and $32.1 million per annum, and at full capacity would be between $800 million and $1 billion annum. Confidential advice to Government ;

Transfer of responsibility for the agreed option from MBIE back to the health system

19 **Agree** that responsibility for progressing the agreed option be transferred from MBIE back to the health system by no later than 30 June 2023;

20 **Direct** MBIE, Manatū Hauora, and Te Whatu Ora to provide the Ministers of COVID-19 Response, Health, and Finance with a detailed transition roadmap for the transfer of responsibility in March 2023;

Transfer of funding for the agreed option to the health system

21 **Agree** to rescind the previous restrictions on transfers of funding to provide for the transfer of responsibility from MBIE back to the health system before 30 June 2023;

22 **Agree** that the funding to progress work on New Zealand's future quarantine and isolation capability beyond 30 June 2023 may be transferred from Vote Building and Construction to Vote Health appropriations only;

23 **Approve** the following changes to appropriations to give effect to the policy decision in recommendation six, with no impact on the operating balance and/or net debt across the forecast period:

If option one is agreed to:

	$m – increase /(decrease)				
	2022/23	**2023/24**	**2024/25**	**2025/26**	**2026/27 & Outyears**
Vote Building and Construction **Minister for COVID-19 Response** Multi-Category Expenses and Capital Expenditure: Isolation and Quarantine Management MCA Departmental Output Expenses: Operational Support (funded by revenue Crown)	(4.512)	-	-	-	-
Vote Health **Minister of Health** Non-departmental Output Expenses: Delivering Primary, Community, Public and Population Health Services		2.256	2.256		
Total Operating	**(4.512)**	**2.256**	**2.256**	-	-

23.1 If option two is agreed to:

	$m – increase /(decrease)				
	2022/23	**2023/24**	**2024/25**	**2025/26**	**2026/27 & Outyears**
Vote Building and Construction **Minister for COVID-19 Response** Multi-Category Expenses and Capital Expenditure: Isolation and Quarantine Management MCA Departmental Output Expenses: Operational Support (funded by revenue Crown)	(7.358)	-	-	-	-
Vote Health **Minister of Health** Non-departmental Output Expenses: Delivering Primary, Community, Public and Population Health Services Multi-Category Expenses and Capital Expenditure: Stewardship of the New Zealand health system MCA Departmental Output Expenses: Public health and population health leadership (funded by revenue Crown)		3.323 0.356	3.323 0.356		
Total Operating	**(7.358)**	**3.679**	**3.679**	**-**	**-**

23.2 If option three is agreed to:

	$m – increase /(decrease)				
	2022/23	**2023/24**	**2024/25**	**2025/26**	**2026/27 & Outyears**
Vote Building and Construction Minister for COVID-19 Response Multi-Category Expenses and Capital Expenditure: Isolation and Quarantine Management MCA Departmental Output Expenses: Operational Support (funded by revenue Crown)	(12.358)	-	-	-	-
Vote Health Minister of Health Non-departmental Output Expenses: Delivering Primary, Community, Public and Population Health Services		3.323	8.323		
Multi-Category Expenses and Capital Expenditure: Stewardship of the New Zealand health system MCA Departmental Output Expenses: Public health and population health leadership (funded by revenue Crown)		0.356	0.356		
Total Operating	**(12.358)**	**3.679**	**8.679**	**-**	**-**

24 **Agree** that the proposed changes to appropriations for 2022/23 above be included in the 2022/23 Supplementary Estimates;

25 **Agree** that any underspends in the Isolation and Quarantine Management multi-category appropriation over and above the cost of funding the option decided in recommendation six be returned to the Crown.

Authorised for lodgement

Hon Dr Ayesha Verrall
Minister for COVID-19 Response