Security classification – Budget Sensitive

Office of the Minister of Health

Cabinet

Funding of COVID-19 Public Health Response

Proposal

1 This paper seeks agreement to provide the health sector with additional financial support for the immediate response to the COVID-19 pandemic.

Relation to government priorities

2 Our public health strategy seeks to delay the onset of community transmission of COVID-19 in New Zealand, and to limit the infection's spread if community transmission occurs.

Executive Summary

3 On 11 March 2020, the World Health Organization (WHO) declared that COVID-19 is now categorised as a global pandemic. At the time of writing, there are a total of 8 confirmed COVID-19 cases in New Zealand, and COVID-19 is now present in over 130 countries.

4 The Ministry of Health (the Ministry) has been working with the Treasury to assess the likely funding required to meet the additional costs associated with the response to COVID-19 within New Zealand.

5 The costs associated with responding effectively to COVID-19 are evolving quickly across government departments and DHBs.

6 On 14 March, Ministers agreed to a package of measures as part of our 'Go hard, Go early, Contain COVID-19'. This package is designed to mitigate the worst impacts of COVID-19 in New Zealand and the Pacific and allows time to prepare for a COVID-19 outbreak.

7 As part of that plan, the health system is scaling up capacity and capability. This package has immediate costs associated with it.

8 This paper seeks the establishment of a tagged contingency of $500.0 million outside Budget allowances.

Background

9 As of 14 March, the Ministry has spent approximately $2.700 million on the initial response to COVID-19. This largely relates to the isolation centre at Whangaparaoa and extended telehealth services (e.g. Healthline), owing to the increase in public queries about COVID-19. These costs cannot be met from within existing baselines.

10 The 'Go hard, Go early, Contain COVID-19' package enables New Zealand to take a holistic response to the spread of COVID-19.

11 The most essential areas of action in the next 30 days are to:

11.1 **Scale up public communications** to ensure people have practical advice and support to contain the virus and stay healthy, and how to self-isolate

11.2 **Ensure the continuity of care in the community**. This has two elements:

11.2.1 Surging support for vulnerable populations, and

11.2.2 Supporting the health workforce to respond

11.3 **Strengthen our ability to test and trace cases** in the community settings

11.4 **Strengthening our ability to treat cases –** in the community and hospital settings as appropriate.

12 To achieve this, our actions over the next 30 days will be split into two phases:

12.1 **Immediate** – public information campaign, upscaling testing, supporting Healthline, surging containment and isolation procedures, establishing Community Based Assessment Clinics (CBAC), and a whole-of-system focus on meeting workforce demand and PPE needs.

12.2 **Medium-term** - support for our hospitals and primary/community providers to deal with a surge of patients, including further advice for caring for people at home.

13 There is a comprehensive set of actions that need to happen across the health sector, in conjunction with DHBs and Public Health Units (PHUs) and others. Costs associated with this activity will likely increase as the Government's response evolves.

14 To support maximum flexibility, I recommend Cabinet agreed to establish a $500.0 million tagged contingency outside Budget allowances to provide for the public health response to COVID-19. As information on the outbreak and the response required unfolds, this figure could be revised.

15 I propose that Cabinet Committee on COVID-19 Response (CVD) has authority to draw down on this tagged contingency, and that in the interim Cabinet agrees, through this paper, to an initial spending package.

Analysis – initial response package for COVID-19

16 Officials have identified key spending priorities over the next 30 days. These main areas of activity are listed below, with further background provided in Appendix One.

17 s 9(2)(f)(iv) [redacted]

18 I recommend that an initial response package of $238.200 million be agreed and appropriated through this paper, as a call against the tagged contingency.

Focus area 1: Scale up public communications and support

19 It is estimated that in the near term, up to $30.0 million will be required to ensure New Zealanders have access to information and support, as follows:

	$m
Public Health campaign across New Zealand including all vulnerable groups via all media channels – to provide people with practical health advice on how they can play their part in containing the virus and staying healthy	10.000
Capacity increase for the Healthline COVID 19 response - Healthline telehealth services are now managing a maximum wait time of 30 minutes with calls reaching a recent peak of 4,300 per day and is progressively increasing based on public anxiety – and this level of support may need to increase depending on the response scenario.	20.000

Focus area 2: Continuity of care in the community

20 It is estimated that in the short term, up to $80.0 million will be required to support the health workforce to respond to COVID 19, as follows:

	$m
Ministry of Health costs to meet ongoing NHCC and system management responsibilities	10.000
Increasing Public Health capacity (including helping to support contact tracing efforts)	40.000
Strengthening workforce capability across DHB provided services including increasing part-time capacity, backfilling and additional capacity through locum support	30.000

Focus area 3: Testing and tracing cases

21 This is an important and sizable area of activity in our response to COVID-19, likely to total over $375.500 million.

22 To ensure we can carry out these essential tasks effectively, this will require a mix of immediate and medium-term spending.

23 The immediate priorities are listed below, and total $125.500 million.

	$m
Purchasing additional ventilated and non-ventilated ICU capacity (private and public)	31.500
Enhanced general practice support and implementing regional responses including Community Based Assessment Centres (CBAC) resourcing, equipment and logistics	50.000
Introducing a GP and Community Health clinical telehealth consultation service	20.000
Increasing ESR and other laboratory Covid-19 testing capacity	5.000
Boost the psychosocial response and recovery plan, focusing on wellbeing promotion campaigns for the general population, as well as tailored guidance and resources for vulnerable population groups.	15.000
s 9(2)(b)(ii) [redacted]	s 9(2)(b)(ii) [redacted]

24 The remaining $250.0 million will be progressed through subsequent drawdowns from the COVID-19 tagged contingency, and more information is provided in the appendix. See below for an indicative list:

	$m
Ensuring NZ has sufficient medicines, facemasks and PPE to allow people and critical health and disability staff protection – this is modelled on Australia's costings and is largely driven by case definition (i.e. testing and need for PPE is linked to the definition for testing)	200.000
Enhanced primary care and community-based services including pharmacy, Aged Residential Care hospital beds, ambulance, supporting people staying at home	50.000

Focus area 4: Supporting vulnerable populations

25 Providing public trust to a vulnerable population is an important aspect to manage COVID-19.

26 s 9(2)(f)(iv) [redacted]

27 s 9(2)(f)(iv) [redacted]

Risks

28 Because of the evolving nature of COVID-19 pandemic, and our response, there is significant uncertainty about the costs associated with our response.

29 The Cabinet Committee on COVID-19 Response will receive further information over the coming weeks and months.

30 There is a high likelihood that further funding decisions will be required during the Budget moratorium. The Treasury is investigating how to provide departments with flexibility during this time.

Financial Implications

31 This paper seeks agreement to establish a "tagged contingency" of up to $500.0 million to be made available to fund the public health response to COVID-19.

32 As noted elsewhere in this paper, estimated costs for programmes of work underway or about to progress, are estimated to cost $238.2 million, and are as follows:

Area of spend	**Total**
	$m
Existing unfunded costs incurred to date	
Current committed costs against Public Health (isolation centre at Whangaparāoa etc)	2.700
Scale up public communications and support	
Public Health campaign across New Zealand including vulnerable groups via all media channels	10.000
Boosting the Healthline COVID 19 response	20.000
Continuity of care in the community	
Potential additional Ministry costs being incurred to meet ongoing responsibilities as well as housing MCDEM (see comment below)	10.000
Boosting Regional Public Health capacity	40.000
Strengthening workforce capability across DHB provided services	30.000
Testing, and tracing cases	
Purchasing additional ventilated and non-ventilated ICU capacity (private and public)	31.500
Enhanced general practice support and implementing regional responses including Community Based Assessment Centres (CBAC) resourcing, equipment and	50.000

logistics	
Introduce a GP and Community Health clinical telehealth consultation service	20.000
Increasing ESR and other laboratory Covid-19 testing capacity	5.000
Boost the psychosocial response and recovery plan to mitigating the immediate and long-term psychosocial impact of COVID-19.	15.000
s 9(2)(b)(ii) [redacted]	s 9(2)(b)(ii) [redacted]
Total estimated costs	**238.200**

33 This paper seeks Cabinet's agreement to appropriate from the Public Health Response to COVID-19 – Tagged Operating Contingency the expenditure forecasts costs outlined in paragraph 32 above, which would leave $261.8 million available in the tagged contingency to meet future potential response expenses and demands.

34 Given uncertainty about the phasing of some expected costs this paper also seeks Cabinet's authority for Cabinet Committee on COVID-19 Response to agree to transfer any unspent funding into 2020/21, with no impact on the operating balance across the forecast period.

35 s 9(2)(f)(iv) [redacted]

Treasury Comment

36 The Treasury supports the establishment of a $500 million tagged contingency to support managing the public health costs associated with COVID-19, including the immediate drawdown of the $238.200 million as outlined in the paper. The Treasury consider a $500 million tagged contingency appropriate relative to an initial costing exercise the Treasury have undertaken to understand the possible public health costs required to manage COVID-19, including an analysis of international public health response packages announced in the past week in Singapore, Australia and the UK.

37 As the paper notes, the nature of the response (and associated costs) will be dependent on the success of early identification, containment and isolation procedures. The approach outlined in this paper enables necessary funding to be available to enable the public health system to respond swiftly to prevent any further spread of the virus.

38 If Ministers wish to make announcements on COVID-19 public health funding, the Treasury recommends announcement of the $500 million tagged contingency. This announcement could also include some of the components being appropriated in this Cabinet paper.

39 s 9(2)(f)(iv) [redacted]

s 9(2)(f)(iv) [redacted].

Legislative Implications

40 There are no legislative implications associated with this paper.

Impact Analysis

41 The Impact Analysis Requirements do not apply to this paper.

Population Implications

42 It is recognised that the impact of COVID-19 on populations with existing high health needs include Māori, Pacific, other ethnicities living in areas of high deprivation, and people aged 65 years and older. Further work is now being completed to feed this into the broader COVID-19 Strategic Response Plan strategy.

43 Activities in this initial spending package are designed to support these at-risk groups.

Human Rights

44 The proposals in this paper are not inconsistent with the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Consultation

45 The Treasury was consulted in the development of this paper. The Department of the Prime Minister and Cabinet were informed.

46 Following a Cabinet decision, the Ministry of Health will progress implementation of the recommendations in discussion with health providers as appropriate.

Proactive Release

47 I do not intend to release the Cabinet paper proactively.

Recommendations

The Minister for Health recommends that the Cabinet:

1 **note** that our public health strategy seeks to delay the onset of community transmission of COVID-19 in New Zealand, and to limit the infection's spread if community transmission occurs;

2 **note** that the nature of the response will be dependent on the success of early identification, containment and isolation procedures, and that there remains significant uncertainty about what additional spending that may be required;

3 **agree** to establish a tagged contingency in Vote Health, to provide for the public health response to COVID-19:

	$m – increase/(decrease)				
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24 & Outyears**
Public Health Response to COVID-19 – Tagged Contingency	500.000	-	-	-	-

4 **authorise** the Cabinet Committee on COVID-19 Response to draw down the tagged contingency funding in recommendation 3 above (establishing any new appropriations as necessary);

5 **agree** that the tagged contingency funding in recommendation 3 above can be drawn down as operating or capital expenditure, and can be drawn down into any Vote as required;

6 **agree** that the tagged contingency in recommendation 3 above will have no expiry date and that at 30 June 2020, the undrawn balance of this tagged contingency will be transferred into the 2020/21 financial year, with no impact on the operating balance and net core Crown debt across the forecast period;

7 **agree** that that the tagged contingency in recommendation 3 above will be established outside Budget allowances, with a corresponding impact on the operating balance and net core Crown debt;

8 **note** that additional funding may be required as the Government receives further information and advice from officials from ongoing work on potential future costs for District Health Boards (DHBs) and other providers in supporting the COVID-19 response;

9 **agree** to immediately progress the following initiatives to delay the onset of community transmission of COVID-19:

Initiative	**$ million**

Existing unfunded costs incurred to date	
Current committed costs against Public Health (isolation centre at Whangaparāoa etc)	2.700
Scale up public communications and support	
Public Health campaign across New Zealand including vulnerable groups via all media channels	10.000
Boosting the Healthline COVID 19 response	20.000
Continuity of care in the community	
Potential additional Ministry costs being incurred to meet ongoing responsibilities as well as housing MCDEM (see comment below)	10.000
Boosting Public Health capacity (including helping to support contact tracing efforts)	40.000
Strengthening workforce capability across DHB provided services	30.000
Testing, and tracing cases	
Purchasing additional ventilated and non-ventilated ICU capacity (private and public)	31.500
Enhanced general practice support and implementing regional responses including Community Based Assessment Centres (CBAC) resourcing, equipment and logistics	50.000
Introduce a GP and Community Health clinical telehealth consultation service	20.000
Increasing ESR and other laboratory Covid-19 testing capacity	5.000
Boost the psychosocial response and recovery plan to mitigating the immediate and long-term psychosocial impact of COVID-19.	15.000
s 9(2)(b)(ii) [redacted]	s 9(2)(b)(ii) [redacted]
Total estimated costs	**238.200**

10 **agree** to provide an additional $2.7 million of operating funding in 2019/20 to Vote Health to provide for costs incurred to date for the COVID-19 response (including for additional telehealth service capacity and the isolation centre at Whangaparāoa);

11 **approve** the following changes to appropriations to provide for the decision in recommendation 9 and 10 above, with a corresponding impact on the operating balance and net core Crown debt:

	$m – increase/(decrease)				
	2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24 & Outyears**
Vote Health **Minister of Health** Non- Departmental Output Expense: Public Health Service Purchasing	213.200	-	-	-	-
National Mental Health Services	15.000	-	-	-	-
Departmental Output Expense: Managing the Purchase of Services (funded by revenue Crown)	8.000	-	-	-	-
Multi-Category Expenses and Capital Expenditure: Policy Advice and Ministerial Servicing MCA Policy Advice (funded by revenue Crown)	2.000				
Total Operating	**238.200**	**-**	**-**	**-**	**-**
Total Capital	**-**	**-**	**-**	**-**	**-**

12 **agree** that the proposed changes to appropriations for 2019/20 above be included in the 2019/20 Supplementary Estimates and that, in the interim, the increases be met from Imprest Supply;

13 **agree** that the expenses incurred under recommendation 10 above be charged against the "Public Health Response to COVID-19 – Tagged Contingency" described in recommendation 3 above, leaving $261.8 million available in the tagged contingency to meet future potential response expenses and demands;

14 **authorise** the Minister of Finance and the Minister of Health to transfer any unspent funding agreed under recommendation 11 to the 2020/21 financial year, as required, with no impact on the operating balance and net core Crown debt across the forecast period;

15 s 9(2)(f)(iv) [redacted]

s 9(2)(f)(iv) [redacted]

s 9(2)(f)(iv) [redacted]

s 9(2)(f)(iv) [redacted]

17 s 9(2)(f)(iv) [redacted]

Authorised for lodgement

Hon Dr David Clark

Minister of Health

Appendix 1 - Health system response to COVID-19

Additional context on activities to be scaled up under the 'Go hard, Go early, Contain COVID-19' all-of-government response.

Focus area 1: Scale up public communications and support

It is estimated that $30 million may be required to ensure New Zealanders have access to information and support, as follows:

	$m
Public Health campaign across New Zealand including all vulnerable groups via all media channels	10.000
Capacity increase for the Healthline COVID 19 response	20.000

1. $10 million will deliver a public health communications campaign – across all media – to provide people with practical health advice on how they can play their part in containing the virus and staying healthy.
2. An additional $3.3 million per month will be required for national telehealth related services based on current demands, and resourcing increases and options (i.e. up to $20 million if this is continued for 6 months). Healthline telehealth services are now managing a maximum wait time of 30 minutes with calls reaching a recent peak of 4,300 per day and is progressively increasing based on public anxiety – and this level of support may need to increase depending on the response scenario.

Focus area 2: Continuity of care in the community

3. It is estimated that $80 million may be required to support the Health workforce to ensure providers can respond to COVID 19, made up as follows:

	$m
Ministry of Health costs to meet ongoing NHCC and system management responsibilities	10.000
Boosting Regional Public Health capacity (including helping to support contact tracing efforts)	40.000
Strengthening workforce capability across DHB provided services	30.000

4. The Ministry will continue to incur additional costs, including support for the National Health Coordination Centre (NHCC), additional ICT costs, and costs associated with housing Ministry of Civil Defence and Emergency Management (MCDEM) staff in the Ministry of Health's Molesworth Street building. Further there is an increased requirement to keep the health and disability sector informed, including providing up to date clinical guidance, advice to all health and disability

professionals on caring for patients as well as looking after their own safety. The additional costs are estimated at around $10 million to 30 June 2020.

5. The Ministry estimates up to $40 million will be required for PHUs to respond to COVID-19. The large proportion of this funding is initially expected to focus on the Auckland Regional Public Health Service (ARPHS), which is at the forefront of New Zealand's public health emergency response; helping to support contact tracing efforts and managing identified cases and their contacts to keep the COVID-19 virus from spreading into the wider community.
6. Strengthening workforce capability across DHB provided services is assumed to include increasing part-time capacity, backfilling and additional capacity through locum support.

Focus area 3: Testing and tracing cases

7. It is estimated that up to $375.5 million may be required to ensure New Zealanders have access to treatment as follows:

	$m
Introduce a GP and Community Health clinical telehealth consultation service in order to ensure that people with greater risk from the virus are treatment in the community and minimise their risk for exposure	20.000
Increase the psychosocial response and recovery plan to mitigating the immediate and long-term psychosocial impact of COVID-19	15.000
Enhanced general practice support and implementing regional responses including Community Based Assessment Centres (CBAC) resourcing, equipment and logistics	50.000
Enhanced primary care and community-based services including pharmacy, ARC hospital beds, ambulance, supporting people staying at home	50.000
Purchasing additional ventilated and non-ventilated ICU capacity (private and public)	31.500
Increasing ESR and other laboratory Covid-19 testing capacity	5.000
Ensuring NZ has sufficient medicines, facemasks and PPE to allow people and critical health and disability staff protection	200.000
s 9(2)(b)(ii) [redacted]	s 9(2)(b)(ii) [redacted]

Introduce a GP and Community Health clinical telehealth consultation service

8. The Ministry is developing options for introduction of GP and Community Health clinical telehealth consultation service to provide direct support to clinicians.

Increase the psychosocial response and recovery plan

9. The psychosocial response and recovery plan for COVID-19 focuses on wellbeing promotion campaigns for the general population, as well as tailored guidance and

resources for vulnerable population groups. The Ministry will partner with organisations such as the Health Promotion Agency and the Mental Health Foundation to develop these resources, which will be delivered largely through digital channels. As part of the psychosocial response, we expect additional resource will be needed to staff mental health and addiction helplines, namely 1737, however, we do not expect this to impact the rollout of Budget 2019 initiatives at this stage.

10. Officals do not expect the response to COVID-19 to impact on the Ministry's capacity to continue to implement Budget 2019 initiatives. We have undertaken contingency planning and are looking at options for remote engagement via video conferencing if needed, for example to progress the evaluation of proposals for youth services and to provide opportunities for oral presentations as part of the upcoming procurement process for kaupapa Māori services.

11. Officals are engaging closely with District Health Boards to understand potential impacts of COVID-19 on maintaining existing mental health and addiction services. Depending on the degree of pressure on the broader health system, providers may need to redirect resources to support local responses and to maintain existing services, rather than to roll out new services. This is not an issue at present, so we are progressing as planned and will continue to monitor the situation.

Enhanced general practice support and implementing regional responses

12. The Ministry estimates up to $50 million will be required for enhanced primary and community support, including Community Based Assessment Centres (CBAC) resourcing, equipment and logistics.
13. General practices are at the frontline of responding to and managing COVID–19. The additional activities, costs and risks inherent in dealing with public health emergencies are at a scale above and beyond the normal day-to-day function of primary care.
14. This funding will be used during these events to enable general practices to participate fully and effectively. General practice teams (doctors, nurses and other staff) are a critical part of the health and disability system and are required to undertake: reporting, assessment, diagnosis, treatment, advice, support and follow up services.
15. This funding would help cover additional costs that will be incurred relating to general practice activities including but not limited to extended consultations, treating non-eligible patients, locum services, a primary care response payment to recognise already incurred expenses and to acknowledge additional pressures alongside increased COVID-19 activity like increased flu vaccinations.
16. Further each DHB is responsible for the delivery of health services and planning at local level and across its region. As part of planning and preparedness it is expected that each DHB will have a clear plan for enabling higher volumes of assessment and investigation of patients with suspected COVID-19 infection across its region.

The approaches required for each region will vary depending on geographical location (urban, rural), characteristics of COVID-19 cases/spread locally (if applicable), and the needs of the population and local communities. There are a number of possible modalities including Community Based Assessment Centres, (CBACs), designated general practices, mobile services, and supported general practice. It is likely that regions will need a combination of these modalities to best meet the needs of their populations. When these will be stood up will vary across each region depending on need, spread and volumes.

Enhanced primary care and community-based services

17. The Ministry estimates up to $35 million will be required for enhanced primary care and community-based services including pharmacy, ARC including hospital beds, ambulance, supporting people staying at home.
This funding would help cover additional costs that will be incurred relating to primary care and community-based services activities including but not limited to supporting urban and rural locum support, scaling up sub-acute hospital capacity and infection prevention and control for aged residential care, introduction of national/regional tasking and coordination functions, virtual community services and home delivery of pharmaceuticals etc.

s 9(2)(b)(ii)

s 9(2)(b)(ii)