

Delta Response Rapid Review

Report for Ministry of Health

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Delta Response Rapid Review: Report for Ministry of Health

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Glossary of terms

BAU	Business-as-usual
CIMS	Coordinated Incident Management System
DHB	District Health Board
ELT	Executive Leadership Team
HSRRP	Health System Response and Readiness Planning Group
IMT	Incident Management Team
MIQ	Managed Isolation and Quarantine
NRHCC	Northern Regional Health Coordination Centre
ODPH	Office of the Director of Public Health
PHU	Public Health Unit
PPE	Personal Protective Equipment
SRO	Senior Responsible Officer
TAS	Technical Advisory Services

Executive Summary

Introduction

This rapid review provides a key stakeholder reflection on the Incident Management response by the Ministry of Health to the Delta outbreak, in the period up to December 2021. The review draws on feedback from 39 respondents, from across the Ministry of Health and the wider health sector. The review also draws on Ministry of Health data on COVID responses and international data on COVID trends up to December 2021.

Findings are summarised below, based on the overarching questions guiding the review. The review was conducted in November-December 2021, and findings relate to the August-December 2021 period.

We note the dynamic and rapidly-moving environment of COVID-19, and that many observations recorded in discussions may well be superseded by events and decision-making. This report focuses on the Delta response and does not seek to comment on the unfolding Omicron response.

What were the strengths of the Ministry's response to the Delta outbreak, in relation to engagement and communication with, and guidance to, the wider health and disability system?

Across Ministry and sector stakeholders, there is a clear positive intent and willingness to deliver the best response possible in a deeply challenging environment, with an overarching goal to protect and respond to the needs of the community.

Extensive preparatory actions were taken before Delta emerged in New Zealand, including:

- An internal Ministry of Health working group to review the Delta response preparation.
- A Department of Prime Minister and Cabinet (DPMC) system readiness group.
- Development of regional capability responses.
- Funding for Māori and Pacific health initiatives, that was provided to District Health Boards (DHBs), Public Health Units (PHUs) and directly to providers.

Many elements of the Delta response indicate a responsive system that was able to be stood up quickly, and building from a solid base of infrastructure, relationships and processes:

- Several of the tactics and policies not only protected New Zealanders, but also prevented the overload of New Zealand's health system to the extent that other countries have experienced.
- New Zealand maintained some of the lowest case and death rates internationally to the end of December, which minimised the risk of health system overload during the peak of the Delta outbreak.

Well-established relationships with the sector were seen to be in place, which supported the rapid response to Delta and rapid scaling of infrastructure. A body of knowledge, infrastructure and practice has developed from the overall COVID response that will support future emergency management, and related areas of work.

A range of policy responses were highlighted as important contributors to the Delta response that reduced the spread of Delta, minimised health system overload and saved lives. These included use of

lockdowns, vaccine mandates, development of the non-regulated workforce, and health worker prioritisation in Managed Isolation and Quarantine (MIQ).

Generally speaking, the Delta response fuelled a more permissive environment to do things differently, and for Māori and Pacific providers to take a whānau-centred approach. Across the response, many highly skilled people are committed to doing the “right thing” for Māori, Pacific, and disabled communities.

Substantial funding was allocated to Māori and Pacific providers in the immediate Delta response, which was distributed quickly. This included:

- \$36 million for the Delta outbreak response to Māori in September 2021.
- \$120 million for the Te Puni Kōkiri-led Māori Communities COVID-19 Fund.
- \$26 million allocated to Pacific health and disability providers.
- \$10 million allocated to transitioning Pacific communities to the COVID protection framework.

The Māori Health Directorate advice maintained a strong focus on Te Tiriti o Waitangi and equity, and had a proactive role in supporting all planning discussions and supported good working relationships between the Ministry, Iwi and Māori and Pacific providers.

Many strengths were seen in the channelling of information and communications from the Ministry, particularly in sharing intelligence and data insights, public communications, and the regular check-ins with the Northern Regional Health Coordination Centre (NRHCC) team in Auckland. Learning from the Auckland experience was shared to support planning in other regions.

What were the challenges encountered through the Ministry’s response?

A common concern from the sector was a perceived lack of operational input into policy development:

- Decision-making structures within the Ministry were unclear for many sector participants.
- The slow pace of policy and guidance to the sector, particularly in Auckland, resulted in operational decisions needing to be made without necessary policies or guidance in place.
- Planning and engagement with primary care was seen as insufficient at the time, for the role it needed to take in the transition to minimisation.

Despite some noted strengths, many respondents noted that the Delta response did not equitably respond to the needs of Māori and Pacific and other vulnerable populations:

- The overall design of the Delta response was seen by many as not based on a pro-equity perspective
- Existing barriers in the health system were seen to further exacerbate inequity.
- Many respondents acknowledged that the strengths of the response in terms of equity were attributable to the Māori Health Directorate, Pacific health team, and Māori and Pacific providers.
- The overall sentiment is that stronger pro-equity accountability is needed to protect Māori and Pacific communities and give effect to Te Tiriti o Waitangi and the partnership between Crown and Māori.

Historic workforce challenges have been exacerbated by the sudden demand placed on the system as it responds to COVID and the Delta surge. Widely raised workforce concerns were capacity, retention, capability, and exhaustion.

The Coordinated Incident Management Structure (CIMS) was perceived as useful and fit for purpose, and provided clear direction and clarity of responsibilities. However, for some, the structure of Incident Management Teams (IMT) response added unnecessary layers and confusion.

Agile management of Delta required the Ministry to provide timely up-to-date information and act on feedback under extreme time pressure. In the rapidly moving Delta response, this was a constant challenge. Respondent feedback indicated in the early stages, the Ministry appeared to struggle in balancing urgency, accuracy and relevancy of information shared for its many stakeholders; however, this improved over time.

The strengths of leadership in the Ministry were noted by many respondents. However, decision-making and Senior Responsible Officer structures were unclear to many. Fatigue is evident in multiple levels of leadership in the Ministry and sector.

To what extent has the Ministry's response to the Delta outbreak helped prevent overloading the health system; and what aspects of the Ministry's response supported or hindered this outcome?

Delta posed very different challenges to earlier strains of COVID, with its rapid transmission, infectiousness and higher risk of needing hospital care. The use and execution of lockdowns, vaccine mandates and the resultant high vaccination rate were seen as the core tactics that have managed the load on the health system. Some respondents acknowledged greater flexibility around Ministry and government processes, with protocols and boundaries softened to make progress as quickly as possible.

The Delta response was a substantive and multi-layered programme of delivery in a very short period of time. There was significant implementation and expansion of systems and capacity in dealing with COVID. This included:

- Contact tracing systems expanding significantly and building comprehensive real-time data systems.
- A 'burst' call centre was stood up to handle additional contact volumes, and surge workforce systems were developed and implemented.
- A National Case Investigation Service was stood up to support the Public Health Units in case investigations with 300 staff, taking about a third of case investigations. This was projected to quickly scale to approximately 600 staff.
- Rapid development and rollout of the Care in the Community framework.

Nevertheless, the adaptability of the Delta response was at times questioned, particularly the extent to which the shift from elimination to minimisation was adopted and the prioritisation of cases. Downstream impacts are also evident in the diversion of workforce and resources towards Delta and away from managing or preventing other health issues.

What can we learn for strengthening and maintaining the COVID response, preparedness and eventual recovery across the sector?

In the short-term, respondents noted a need for stronger locally-led solutions, and building system-wide responses nationally. In the medium-term, planning for managing COVID alongside ongoing

system demands will be needed. Learning from the Delta response indicated that a clear strategy is needed for COVID to be managed within business-as-usual and other health system pressures, particularly in implementing minimisation and ongoing disease prevention approaches.

At the time the review was undertaken, the health system was grappling with moving to a system that is managing the virus within the community, along with the added complexity of the health reforms. Many respondents noted that there is a need for longer term planning, streamlining of processes and functions, and utilising the wider health system differently.

Respondents identified a need to resolve communication challenges, increasing trust, and building greater collaboration with the sector. This includes ensuring Māori and Pacific are more closely involved in mainstream planning and decision-making. More broadly, learning from the Delta response indicated a need to strengthen sector communications, and to further refocus communications with the public.

What are the capability requirements for COVID response, preparedness and recovery?

Overall, the need for comprehensive planning with a national aim and local focus was seen by respondents as an essential missing element that would support DHBs and localities in managing the system and preventing overload. A balance is needed between central control and local decision-making and innovation.

Key areas of development highlighted by this review are:

- **Engage Māori and Pacific leadership and providers** to further develop and support equity responses to COVID and more widely in the health system, with a clear line of sight to Te Tiriti o Waitangi.
- **Improve both short-term and long-term capacity and capability planning.** This extends into the primary care and cross-sector workforce who will be needed to support communities in a comprehensive wellbeing response.
- **Deliver greater clarity on responsibility and accountability** to support sector activity, along with giving greater strength to locally-led solutions.
- **Resource leadership, and the wider workforce, to ensure they have the capacity to rejuvenate** individually and collectively; this will help deliver a robust and adaptive ongoing response to COVID.

Prioritised recommendations

Within the body of this review, each of the thematic areas contain a detailed set of opportunities for the future related to that domain. There is some crossover between the themes, as each represent the interconnected workings of the health sector, and in particular those who were involved with the response to the COVID Delta variant.

The 30 interviews with 39 individuals provided insight from people involved from different standpoints within the Delta response, in the midst of a rapidly changing environment and the international emergence of a new variant (Omicron).

The prioritisation of response opportunities within the scope of the review have been based on what has been heard from those within the system, and the urgency and impact that could be realised with the seizing of the opportunity. Detailed opportunities within the report give further actionable and tactical suggestions to contribute to a shift at scale.

We are also conscious of the speed with which decisions and recommendations can become out of date in the context of COVID. The recommendations that follow were developed with a more medium-term perspective in mind.

Three consolidated areas have been prioritised based on what has been heard from review participants: equity-first approach and outcomes, response cohesion, and securing the future of the workforce.

Equity-first approach and outcomes need significant work

The most significant opportunity noted across the interviews, and particularly closer to the communities was the potential to impact positive health outcomes for Māori, Pacific and vulnerable populations (such as people with disabilities and people who are experiencing homelessness).

Recommended actions:

- Partner with Māori and Pacific teams to further develop and support pro-equity approaches and a broader system culture, to ensure an intentional focus on equity in the design and implementation of sector-wide responses.
- Partner with those who have the skills, knowledge and ability to design and develop approaches that connect with these populations.
- Maintain and prioritise equity-based forecasting and success indicators, with active assessment and monitoring of impacts on health and social outcomes for Māori and Pacific populations, as well as people with disabilities and other vulnerable populations.
- Resource comprehensive and consistent support services for disabled people and their whānau in pandemic responses, which protects both lives and quality of life.
- Establish more systematic collection of disability-focused service and outcomes data to inform service planning and responsiveness.

Bolstering response cohesion

The cohesion of the health sector while in an extended emergency response mode has been variable, based on the range of responses related to communication, planning, and system responsiveness.

Recommended actions:

- Improve clarity in roles, responsibilities and decision-making structures and processes between central agencies and regional response teams.
- Improve information sharing between central agencies and regional response teams.
- Ensure the national plan for COVID-19 response and management enables local variation and innovation, in a way that is built into the functions, needs and pressures of business-as-usual health sector activity.
- Partner with the sector and affected communities to implement more proactive and inclusive learning and development cycles, to build lasting responses to critical system challenges; these should combine needs identification, analysis and resolution.
- Develop/strengthen care and funding models that support differentiated/prioritised responses to COVID across prevention, primary care and hospital-level care.

Securing the future of the workforce

As the backbone of the system, the workforce (nearly universally) reported fatigue, burnout, stress and for some a feeling of failure. The reports ranged from top level managers to frontline staff. Some noted the number of people exiting or planning an exit.

Different options for supporting and sustaining our current health workforce in its entirety (doctors, nurses, allied health, non-regulated, etc) were suggested by many. At its core there is a need to identify fully, assess and address fundamental underlying contributing factors, to change this trajectory in what can be recognised as a prolonged trauma response as a result of COVID.

Redeployment of the frontline workforce during the Delta response was regarded positively, though workforce shortages loom for health sector leaders where there may not be staff to redeploy.

Recommended actions:

- Establish a nationally supported workforce development plan (short and long term) that focuses efforts on developing a more culturally diverse, 'homegrown' workforce and also leverages the position of the Ministry to smooth the way for overseas entrants.
- Refine inter-regional modelling and surge planning for future periods of peak system demand.
- Resource and support the primary care workforce to be able to provide care in the communities, to better distribute care responsibilities throughout the service provision system.
- Channel newly-established COVID workforce capacity (e.g. vaccinators), into key areas of need such as restoring other immunisations to pre-COVID levels.

1. Introduction

Background and scope

This review provides a key stakeholder reflection on the Incident Management response by the Ministry of Health to the Delta outbreak, drawing on interviews with 39 senior stakeholders from across the Ministry of Health and the wider sector. The intent of the review was to provide rapid feedback and reflections from the health sector on the Ministry of Health incident management response to the emergence and management of the COVID-19 Delta variant in New Zealand, and insights for future emergency response preparedness and management.

The review provides an opportunity for reflections from senior staff or leaders in the Delta response, in the midst of a rapidly changing and complex environment. This document captures the experiences and insights of people in a variety of roles, exploring the strengths, challenges and learning for future implementation in relation to the Delta response. The review was not intended to provide an in-depth analysis, nor a comprehensive evaluation of the Incident Response.

Key areas of focus guiding this review are the following:

1. What were the strengths of the Ministry's response to the Delta outbreak, in relation to engagement and communication with, and guidance to, the wider health and disability system?
2. What were the challenges encountered through the Ministry's response?
3. To what extent has the Ministry's response to the Delta outbreak helped prevent overloading on the health system; and what aspects of the Ministry's response supported or hindered this outcome?
4. What can we learn for strengthening and maintaining the COVID response, preparedness and eventual recovery across the sector?
5. What are the capability requirements for COVID response, preparedness and recovery that need to be planned for in the light of these findings?

Ministerial decisions, and response actions of the wider health and disability system are out of scope for this review.

We stress that this review took place in a rapidly unfolding environment over November-December 2021. This was a time when decisions were being made and implemented at pace, and as a result, some observations and reflections made during the review were outdated by the time of the review's conclusion. For example, by project conclusion, the future outlooks had shifted from 'new variants' to the likely arrival of Omicron and its potential implications. We have endeavoured to maintain focus on reflections captured in relation to the Delta response that can inform future COVID-19 incident management responses.

Approach to this review

This review is a qualitative exploration of the experiences and reflections of people connected to the Incident Management response from within and outside the Ministry of Health. Those taking part were in senior roles, and in a strong position to offer strategic insights into the response delivery, including areas of strength and improvement, and key issues to consider in the future. Respondents were able to reflect openly in discussions on the Delta response, in a context that was dynamic and rapidly evolving, both within New Zealand and internationally. This type of review is valuable for exploring a complex issue; uncovering both the successes and challenges encountered in the unfolding responses; and in the process generating ideas, providing insight and supporting continuous improvement.

A diverse and experienced team undertook this review, with expertise including social science research and evaluation, health services management, kaupapa Māori evaluation, and information and learning systems.

Data informing this report was gathered through interviews and group discussions with 39 senior people from within the Ministry of Health, and sector stakeholders from a range of organisations, including district health boards, public health units, the Northern Region Health Coordination Centre, and an advisory panel to the Ministry.

Participants were invited by the project sponsor in the Ministry of Health to take part, with follow-up by the research team to arrange interviews. Further invitations were subsequently made to ensure a wide range of perspectives were included in the review, particularly Māori, Pacific and disability perspectives. Participation was entirely voluntary and feedback is reported anonymously, by agreement with respondents.

The key selection criterion for interview participation was a direct connection to the Delta response from within the Ministry; and for sector stakeholders, a regular connection to the Ministry for day-to-day decision-making and action in response to Delta.

Overall, 30 interviews with 39 participants were conducted in a relatively brief time period for data collection (five weeks from mid-November to mid-December 2021). Those participating were all in demanding roles, and we are grateful that so many were able to take part in the midst of a sector working at pace.

Interviews generally lasted 30 minutes to one hour, with some running longer where there were more than one respondent taking part. All interviews were recorded and transcribed.

Data was analysed progressively on a weekly basis, building insights as the project unfolded. Iterative sense-making was woven from multiple perspectives across the research. In preparation for this report, all transcripts were coded and re-analysed thematically to ensure all relevant perspectives were captured.

The review provides a thematic capture of feedback from leaders in the Delta response, and reflections for future COVID response and management. The overarching themes for this report are:

- **Contextual factors that influenced the Delta response.**
- **System responsiveness and management.**
- **Policy advice and implementation.**
- **Equity responses.**
- **Workforce.**
- **Information sharing and learning.**
- **Strategic leadership.**

Each of the themes listed above are explored within the overarching questions guiding the review.

We note the dynamic and rapidly-moving environment of COVID, and that many observations recorded in discussions may well be superseded by events and decision-making.

This review does not explore in detail the patterns of Delta onset, transmission and management. The response to Omicron is similarly outside scope.

2. Context

Legacy strengths and challenges

A range of issues were highlighted that provided context to the Delta response, which gave strength to, and in some cases impeded the Delta response. These included the momentum of earlier COVID responses, the structure of the health system, a legacy of systemic underfunding, and system changes underway. Delta itself was a significantly different variant with high transmissibility that in itself posed a major challenge.

Sector dedication and momentum of earlier COVID responses

A pivotal backdrop to this review was the dedication, preparedness and momentum of the sector, which had progressively developed since the first response to COVID in early 2020. The widespread willingness, commitment and dedication of the Ministry and the sector to respond comprehensively to COVID over nearly two years was often raised.

Further, the sector was widely seen to have built systems, capacity and learning that supported and enabled the rapid response to Delta that unfolded. This backdrop ensured that there were systems, processes and infrastructure in place, led by established personnel in the Ministry and in the wider sector. There was also a cross-sectoral commitment to respond to Delta when the outbreak was first detected.

The challenge of Delta itself

Delta was noted by some respondents as a very different form of COVID compared to previous variants. Delta has many differences to earlier variants of the virus, with scientific research showing that:

- Delta may cause people to develop more serious COVID-19 illness than other variants of the virus, and people with a Delta infection may be at higher risk of needing hospital care.
- The likelihood of infecting others is very high because Delta is so transmissible.
- People with Delta infections appear to have a higher viral load and for a longer period of time than those infected with the original virus or other variants.
- The time from exposure to the virus until the first positive test is shorter for the Delta variant.¹

These were noted in the report of the Strategic COVID-19 Public Health Advisory Group chaired by Professor David Skegg, which advised on the need for a review of health system capacity and management systems for dealing with large outbreaks of COVID-19. The report advised that the review should cover primary care, medical ward capacity, equipment for non-invasive ventilation and intensive care facilities. The report also recommended that because the impact of the Delta variant

¹ <https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-health-advice-public/about-covid-19/covid-19-about-delta-variant>

was likely to cause major outbreaks, borders should not immediately open up, and that vaccination be extended to people aged 12-16 years of age.²

The nature of Delta therefore created a significant challenge, and required a whole of system response in a way that had not been encountered previously.

Health system structure and responsiveness

The devolved nature of the health system was commonly raised as an underlying challenge. The Ministry has limited levers of funding and influence, and does not typically have a 'command-and-control' role. There was acknowledgement of the challenge the Ministry faces in providing stewardship to a complex sector, with one respondent noting, "the territory is always more complicated than the map says it is." Aspects of the complexity of the sector included the following:

- DHBs have a significant independent role in responding to COVID, alongside PHUs, and independent providers (including Māori and Pacific providers), each with their own leadership teams and governance.
- The relationships between Ministry, DHBs and PHUs are at times complex; PHUs are owned by DHBs but funded by the Ministry, and it was reported that PHUs look to the Ministry of Health for operational leadership.
- Regional structures are in place for emergency responses, which existed prior to COVID. The Northern Regional Health Coordination Centre (NRHCC) was most active due to the substantial level of Auckland-focused activity. The NRHCC was stood up in January 2020 in response to COVID, and shares resources across the four Northern DHBs in a single incident control centre.
- The Ministry itself responds to COVID-19 across all its directorates, including but not limited to the dedicated COVID-19 Directorate.
- The system complexity itself ripples out to other areas of public sector activity, including police, transport, defence and business regulation. Each have important roles in responding to COVID, with their own operational structures and networks of influence.

Historic health system underfunding and commissioning barriers

The response to Delta, and to COVID more broadly, occurred within a context that many described as historic under-funding in the health system, and particularly public health. These meant that the workforce and related infrastructure of the sector was under-developed to respond to COVID from the outset. This included the public health workforce in place to respond to COVID in its early days, the challenge of bringing on new staff unfamiliar with the sector, and shortage of staffing and beds in secondary care, including ICUs. Despite this, it is evident that the system was highly successful at responding to COVID in its first waves, and the consultation undertaken in this review highlights some key successes against Delta.

Uncertainty of funding and rigidity of funding processes are longstanding health sector issues. In the context of Delta, many health providers continue to work within one-year funding cycles, with commissioning and procurement processes commonly not working to longer timeframes. This also means that many staff are employed on short-term contracts, particularly roles that focus entirely on

² Strategic COVID-19 Public Health Advisory Group. 2021. Future of the Elimination Strategy. <https://www.beehive.govt.nz/sites/default/files/2021-08/Embargoed%20Skegg%20advice.pdf>

the COVID-19 response. As Delta quickly became a critical issue requiring urgent local responses, many providers stood up responses simply to meet local needs, working in the hope that funding would be forthcoming.

Many respondents felt that there was a legacy of a system that is generally unresponsive to Māori and Pacific people, across design, decision-making and planning. This contributed to the unevenness of responses to these groups, and what many saw as the lack of a pro-equity response. This is discussed further in the equity section (page 31).

Health system changes

The significant reforms to the wider health system (under development at the time of writing, with implementation in July 2022) were commonly raised as a backdrop to the Delta response. In many respects, COVID was seen to highlight the challenges of the current system, but it has also highlighted the difficulty of substantial system change running in parallel with the Delta response. The parallel health system reforms, even with the opportunities they provide, were also contributing to system stress at a time when the sector is working at pace.

Putting New Zealand's Delta response in an international context

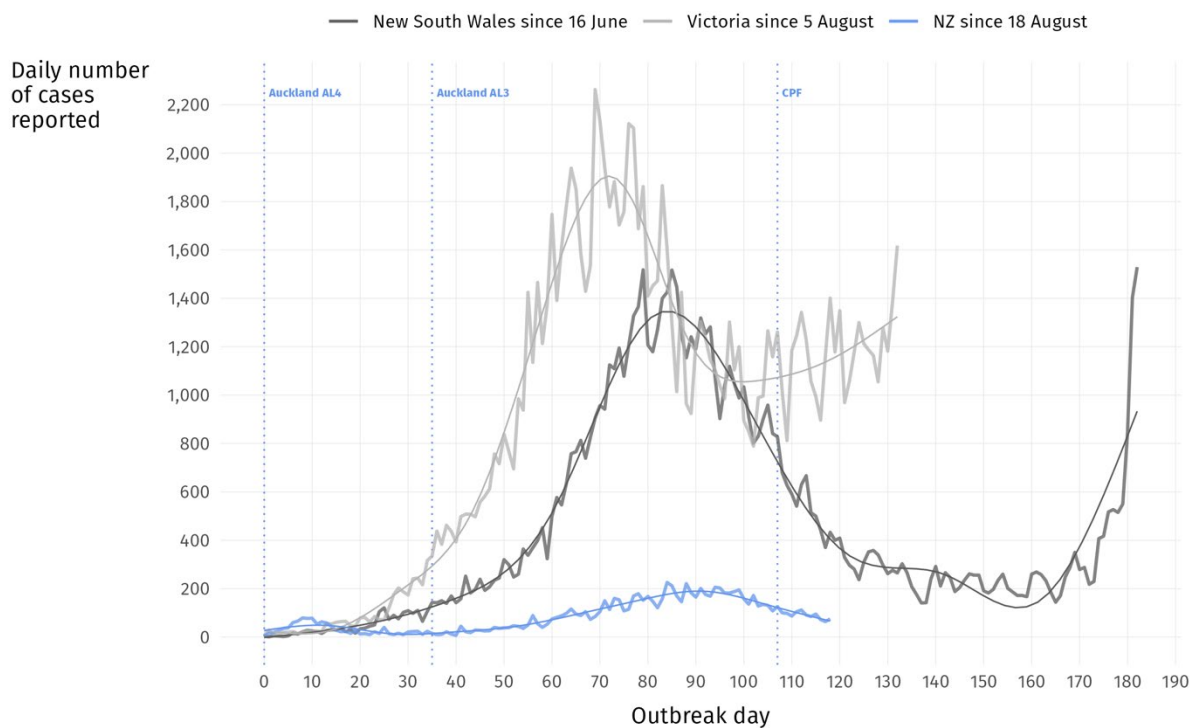
This review highlights a range of successes, challenges and learning from the Incident Management response to the Delta outbreak. Even with some limitations of the response, New Zealand continues to perform well internationally in preventing COVID cases and deaths, and minimising health system overload.

Daily COVID community cases

To give further context for the Delta response, we briefly draw on international benchmarks for COVID response and management. Overall, New Zealand has succeeded in containing the spread of Delta. New Zealand has some of the lowest case and death rates internationally. There are however significant sub-population differences within New Zealand, and the challenges of the response and outcomes for Māori, Pacific and disabled people are discussed in later sections.

Figure 1 shows the substantially lower daily case trends for New Zealand (as at 17 December 2021), compared to Victoria and New South Wales. The chart compares the Delta variant outbreak in New Zealand since Auckland moved to Alert Level 4 on 18 August, to the Delta outbreaks in New South Wales (since 16 June) and Victoria (since 5 August). The first day the outbreak was detected is used as the starting point for each trendline, regardless of the actual date. Note the rapid tail-end growth in cases in New South Wales and Victoria, understood to be in part due to loosening of restrictions, and the early stages of the Omicron outbreak in the community in December 2021.

Figure 1: Daily Delta outbreak cases in New Zealand, New South Wales and Victoria³



OECD comparators

The agility and comprehensive nature of the New Zealand response to COVID-19, including the Delta variant, has clearly delivered outcomes that have been more successful than most other countries. Figure 2 on the following page details New Zealand’s performance in a range of international benchmarks, compared to other OECD countries (as at 20 December 2021). For COVID case numbers and deaths overall, as well as in the previous 14 days, New Zealand continued to be at the lowest end of the range in the OECD. New Zealand’s overall vaccination rates at the time were well into the top half of the OECD and by February 2022 were in the top 10 of the OECD.⁴

³ Sourced from Aaron Schiff, collaborating data scientist using Ministry of Health and international data

⁴ Sourced from Our World in Data, COVID-19 Data Explorer (<https://ourworldindata.org/covid-vaccinations>)

Figure 2: COVID-related cases and deaths, NZ and other OECD countries, 20 December 2021⁵



AT: Austria, AU: Australia, BE: Belgium, CA: Canada, CH: Switzerland, CL: Chile, CO: Colombia, CR: Costa Rica
 CZ: Czechia, DE: Germany, DK: Denmark, EE: Estonia, ES: Spain, FI: Finland, FR: France, GR: Greece
 HU: Hungary, IE: Ireland, IL: Israel, IS: Iceland, IT: Italy, JP: Japan, KR: South Korea, LH: Lithuania
 LU: Luxembourg, LV: Latvia, MX: Mexico, NL: Netherlands, NO: Norway, NZ: New Zealand, PL: Poland, PT: Portugal
 SE: Sweden, SI: Slovenia, SK: Slovakia, TR: Turkey, UK: United Kingdom, US: United States

⁵ Sourced from Aaron Schiff, collaborating data scientist, using Ministry of Health and international data

3. System responsiveness and management

System strengths

Many elements of the Delta response indicate a responsive system that was able to be stood up quickly, and building from a solid base of infrastructure, relationships and processes. The Ministry of Health, DHBs and partnering government agencies moved rapidly on multiple fronts in response to Delta. Several of the tactics and policies not only protected New Zealanders, but also prevented the overload of New Zealand's health system to the extent that other countries have experienced.

The use and execution of lockdowns, vaccine mandates and the resultant high vaccination rate were seen as the core tactics that have managed the load on the health system. Several respondents noted that overload was also managed well. Some respondents acknowledged greater flexibility around Ministry and government processes; with protocols and boundaries softened to make progress as quickly as possible.

Rapid response and mobilisation

Extensive preparatory actions were taken before Delta emerged, including an internal Ministry of Health working group to review the Delta response preparation; a Department of Prime Minister and Cabinet (DPMC) system readiness group; development of regional capability responses; and funding for Māori and Pacific health initiatives that were provided to District Health Boards (DHBs), Public Health Units (PHUs) and directly to providers.

The COVID-19 Directorate Incident Management Team (IMT) was rapidly stood up to respond to Delta, and this enabled an immediate national response. The health sector was able to mobilise quickly to build systems and capacity. Tactical and advisory groups were stood up to coordinate across the DHB system, with strong leadership and organisation.

There was significant and rapid implementation and expansion of systems and capacity in dealing with COVID; examples cited included:

- Contact tracing systems expanded significantly and moved from individual spreadsheets to comprehensive real-time data systems.
- A 'burst' call centre was stood up to handle additional contact volumes.
- Surge workforce systems were developed and implemented.
- A National Case Investigation Service was stood up to support the Public Health Units in case investigations with 300 staff, taking about a third of case investigations. This was projected to quickly scale to approximately 600 staff.
- Rapid development and rollout of the Care in the Community framework.⁶

⁶ <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-health-professionals/caring-people-covid-19-community>

The Care in the Community framework was notable in that it was first considered in September 2021, and was operationalised within a few short months to enable people diagnosed with COVID-19 to stay in their own homes as an alternative to managed isolation and quarantine. The approach covered clinical care, public health services, and welfare needs and support.

Building from systems and learning in place

There was a solid base of systems and learning in place from previous outbreaks, acknowledged throughout the interviews. Scaling happened quickly, and continues to evolve, with technology as a significant enabler both within the health system and for the users of the health system (such as COVID tracking, vaccination records and telehealth).

“We’ve gone through a very kind of cottage industry pace of contact management, we are now spiralling into an industrial sized of that cottage industry, so it’s effectively an industrial version of that where we need to shift to next is an electronic version where there is ... an electronic pathway for managing one to two thousand cases a day that doesn’t involve a human touch, like what you’re seeing overseas, and that’s a big shift.”

Systems coordination

The Coordinated Incident Management Structure (CIMS) was generally seen to be fit for purpose, providing a good process to ensure clarity of actions and responsibilities, and with regular meetings. Overall it was viewed as clear and straightforward to follow.

The 12 Public Health Units, once separate and relatively contained, were, by the time of the review, seen to be working “seamlessly together and sharing work between them on a regular basis.” Surge workforce systems and the workforce were seen to respond well; and redeployment of resources helped meet some of the demand. Cross-sector work was also mobilised quickly in some of the tactical responses, such as the Auckland border and then the health response for border testing, which was established within 10 days.

From the beginning to the end of the review period, it was evident that the system was constantly moving at pace in responding to Delta. As an indicator, early responses in the review noted an emergent need for advice to the public regarding managing COVID illness within the community with associated wraparound supports; within a week, guidance had been issued. Toward the end of the short review period, discussion about Care in the Community as a wellbeing response were becoming more common.

Adaptability and complexity in responding to Delta

Delta posed very different challenges to earlier strains of COVID. The adaptability of the response was questioned, particularly the extent to which the transition from elimination to minimisation unfolded. Downstream impacts are evident in the diversion of workforce and resources towards Delta from other areas of health sector activity.

At the time the review was undertaken, the health system was grappling with moving to a system that is managing the virus within the community, along with the added complexity of the health reforms. Many respondents noted that there is a need for longer term planning, streamlining of processes and functions, and utilising the wider health system differently.

Challenges in system responsiveness and management

Delta was widely recognised as very different to earlier strains, and whilst in the first month of the outbreak it got close to being brought under control, it became embedded in harder to trace populations. It was evident that the previous way to contain a COVID outbreak had become outdated.

As is noted, the Ministry of Health moved rapidly in both preparation for and response to Delta; however, the adaptability of the Ministry as the Delta situation unfolded was unclear for many outside of the Ministry. Many respondents were unsure where the strategic decisions were being made to enable pivoting from elimination to minimisation, and to reduce pressure on the health workforce. Some respondents noted how quickly Ministry teams were assembled in the response, and there was some concern of fragmentation and working inefficiently because those newly recruited and inducted are unaware of systems or channels in place.

“There is a little bit that talks to fragmentation within the Ministry as well, there is probably four different Directorates doing different work in this through technology, COVID, Policy and Health System Preparedness and then there is the Population Health Directorate with the Officer of the Director of Public Health.”

Downstream impacts

The concentration of workforce and resources on managing the system to reduce the impact of Delta had downstream impacts on other parts of the health system.

Redirecting staff and resources to COVID was understood, but this was also seen to at times negatively impact on patient outcomes in other care areas (non-COVID care). There was also concern about the downstream impacts on other communicable diseases; nationally, the health system had under-delivered on measles catch-up programmes in young adults, and childhood immunisations were well below optimal levels.

Many noted that they (and their teams) were working within short horizon timeframes (and these timeframes were within 3-6 months at a maximum, some even less at 3-4 weeks). While they were aware that there would be additional downstream impacts on the health system, they noted little evidence of longer-term planning, partly due to capacity issues.

“I’m not hearing anything about how what we’re trying to do now is building a platform for living with COVID and other pandemic influenzas and other things, viruses, how is this actually providing a platform for the future. It’s almost like we’ve got so fixated on the thing that we can see in front of us, we’ve forgotten that there is a whole other wave coming beyond that which could be just as catastrophic for the system, for people.”

Considering COVID within business-as-usual

Moving to a system that is managing the virus as endemic within the community is noted as the next stage that the health system is grappling with. Recovering from the initial surge in Auckland region and moving to a minimisation strategy also meant considering the management of COVID alongside BAU. At the time of interview, other regions were anticipating an initial surge and then recovery period, recognising that this timing may be different in different regions.

“I think the contribution in terms of the strain is just the longevity of the COVID response within [Auckland] and probably the thinking on how to manage that sustainably and long term.”

Several people noted that there is untapped potential to engage other areas of the system, such as primary care as the main point of contact with the health system for the majority of the population. However, they noted that the absence of a framework and funding model has meant primary care is not resourced for managing COVID in conjunction with the wider system and there is a continued reliance on public health, which is overstretched.

Several operational functions related to the COVID response were cited as creating pressures on the system and where adaptation and/or streamlining were needed. The opportunities were wide and varied, including (but not limited to): differential responses to presentations of patients presenting with COVID, rationalisation of required data reporting to the Ministry of Health, and streamlining Ministry of Health processes for allocating resources.

“It’s that real paradigm piece ... there’s a shift now going to be needed... about how do we continue to manage COVID and then work on continuing to deliver in the health system.”

Parallel health system reforms

The health system reform process and changes have added another layer of complexity and pressure to an already stressed system (Ministry of Health and DHBs). Whilst Delta has highlighted the challenges of the current system, the parallel health system reforms, even with the opportunities they provide, are also contributing to system stress at a time when the sector is working at pace.

Stressful components included (but were not limited to) loss of leadership and institutional knowledge at the local level as the DHBs are disestablished mid-2022, as well as the planning, staffing and organisational change management that is required within the Ministry and the DHBs for a successful outcome.

Looking to the future: System responsiveness and management

Overall, the need for comprehensive planning with a national aim and local focus was seen by respondents as an essential missing element that would support DHBs and localities in managing the system and preventing overload. At the time of interviews, a balance had not yet been found between central control and local decision making and innovation.

FUTURE FOCUSED THEMES and ACTIONS

Implement comprehensive planning

Overall, the need for comprehensive planning with a national aim and local focus was seen as an essential missing element that would support DHBs and localities in managing the system and preventing overload. Some respondents were looking ahead to the future and what managing COVID will mean for the health system. Several noted that a longer-term plan is needed that takes into consideration the other functions, needs and pressures of the health system at an operational level in order to plan for and manage COVID over the short and medium-terms, while still maintaining ongoing system delivery.

“It feels like we are flying a plane and building the plane at the same time but not everybody is sure of what sort of plane we’re building.”

Balance local vs national control and decision-making

There is a balance to be achieved between central control and local decision-making and innovation as the system transitions towards minimisation and COVID management. Sector respondents spoke of a need for greater local flexibility and decision-making, as well as integration across currently siloed areas of the health and disability system; this fundamentally requires trust between parties as the foundation of a collaborative and collegial environment. Regional support structures were noted by some as holding good potential for system responsiveness and coordination. Care in the Community, as an emergent cross-ministry initiative, was seen as holding potential but required more change management support and coordination to ensure cohesion between MSD and local health-led initiatives.

Align operational requirements with system needs

The COVID response highlighted the value of rapid, evidence-based and adaptive approaches. For the future, matching operational requirements to system needs was a theme that emerged in discussions. This was inclusive of (but not limited to) streamlining and/or truncating processes during time-sensitive crisis points, quick adaptation of policy and advice to community and community health system needs, prioritising ongoing data reporting requirements, and providing intelligence to local areas, and tailoring analysis on specific at-risk areas to inform responses.

“I think that a lot of the dynamism that COVID-19 generated would be useful to keep, to get going, to be snappier in decision-making and reduce some of the bureaucracy if we can.”

Build primary care leadership

Moving from elimination to management and suppression would mean that primary care will need to take on a much larger role than previously; they will be owning the core relationship with individuals and communities. Gearing up the primary care sector to respond to COVID, and the frameworks and funding model to enable the response as ongoing care is an important step in system management. This needs to be inclusive of welfare and wrap-around responses, supported locally for potential outbreaks and surge response.

“Get the funding out there, get the clinical pathways out there, get something that’s agreed on so the sector feels they have some sort of national guidance... I think that would be a big win.”

4. Policy and operational advice

Relationships, infrastructure and key policy responses

Well-established relationships with the sector were seen to be in place, which supported the rapid response to Delta and rapid scaling of infrastructure. A body of knowledge, infrastructure and practice has developed from the overall COVID response that will support future emergency management, and related areas of work. A range of policy responses were highlighted as important contributors to the Delta response, including lockdowns, vaccine mandate, non-regulated workforce and health worker prioritisation in MIQ.

Relationships and infrastructure in place

Through 18 months of managing COVID, many noted that the Ministry had established a strong way of working with solid relationships, systems and processes across its directorates, and across the sector. Despite its multi-layered complexity, the sector was seen to come together well in response to COVID. Sector respondents also spoke of key individual relationships held within the Ministry that were highly valued, and seen as striving to ensure the sector worked at its best.

“I think we’ve managed to keep people on task and engaged through what’s a challenging time. Relationships have stayed and maintained well which is important. Structures do one thing but relationships get things done and the ability of the system to reach out into each other and help each other I think on the whole has gone quite well.”

The rapidity of standing up a response and the development of surge capacity were also seen as important positive contributors to the Delta response.

The ability to build an explicit COVID-focused directorate over the 18 months prior to Delta meant there was already the infrastructure and clear known processes in place. The scalability of the infrastructure was a further strength. In a rapid period of time, the system expanded rapidly in contact tracing, Auckland boundary management, and testing regimes for essential workers. A call centre was established that at one stage managed 6,000 contacts during Delta, and a national case investigation service was in place.

Respondents noted that the legacy of COVID adaptation will support preparation for future emergencies, and also has built a body of knowledge, infrastructure and practice that can be applied to other areas of activity, such as wider vaccination work.

Notable policy responses

A range of policy responses were seen as important contributors to the Delta response. These included:

- Implementing Levels 4 and 3 lockdowns were seen as important contributors to supporting the health system.
- Enabling the non-regulated workforce to vaccinate in a limited capacity to reduce workforce pressures.
- The value of the vaccine mandate in lifting vaccination rates and helping prevent system overload.

- The availability of Managed Isolation and Quarantine (MIQ) as the first line of protection against COVID.
- Funding support directly to Māori and Pacific providers.
- Ensuring devices for PPE fit testing throughout the country.
- Prioritisation of 300 spots for essential health workers for MIQ.

Leadership by the Office of the Director of Public Health, with a very small team, has provided significant public health expertise across the system and inputted on critical areas of policy development; some noted however this would benefit from further resource and strengthening.

Policy and operational interface, and wider system connections

A common concern from the sector was a perceived lack of operational input into policy development. Decision-making structures within the Ministry were unclear for many sector participants.

The slow pace of policy and guidance to the sector, particularly in Auckland, resulted in operational decisions needing to be made without necessary policies in place. Planning and engagement with primary care was seen as insufficient for the role it needs to take in the transition to minimisation.

Unclear lines of accountability

Many outside of the Ministry spoke of a lack of clarity of who the policy owners or senior responsible officers (SRO) may be, and who is making decisions, with fragmentation and no clear sense of how to escalate issues. At times such as these, the personal networks within the Ministry would often be utilised to find resolution.

Policy and operational interface

Because of time pressures and urgency of the Delta response, the policy process has often been truncated. Partly as a result, there was seen to be a lack of operational input into policy development. Across a range of areas, including workforce capacity, and responses to Māori and Pacific communities, there were concerns that advice and recommendations from the Northern Region were not filtering through to senior levels and translating into policy decisions, and subsequently eroding trust. This also flows into implementation challenges for people enacting policy in the sector.

The lack of identifiable formal channels affected many respondents' ability to influence the Ministry and relevant teams. Many respondents from outside the mainstream Ministry teams perceived a misalignment of the response and 'on the ground' intelligence. People with operational knowledge and technical expertise felt they were being excluded from policy development, resulting in a view that the mainstream Ministry teams did not fully understand the lived reality of the Northern region Delta context. A lack of clarity about responsibilities made it difficult to communicate 'up the chain'.

"Auckland and the Northern Regions learnt a lot. We've got a lot of people who know what they're doing, and are extremely capable and experienced in managing an outbreak. Our knowledge and expertise should be used to help inform the rest of the country. Otherwise I think they're going to have a pretty tough period."

Slow pace of policy and guidance

In Auckland, which was at the centre of the pandemic response, a clear theme of interviews was that Northern teams were often waiting on the Ministry for guidance or policy. For some, the slow pace of key policy developments, alongside at times points of rapid change and mobilisation, were not keeping up with the reality on the ground of an exhausted workforce. This was particularly in areas such as contact tracing and testing, despite repeated concerns raised.

“I don’t feel that the policy advice that comes out is being sufficiently led by the Ministry in a way that provides an alternative, and to elaborate on that, if we can’t keep going at this pace, then we need a map for what to do lesser or what to do differently and that needs to be thought out in advance.”

In the absence of policy, teams in Auckland felt required to make operational decisions. These were either subsequently adopted by policy/guidance, or different policies emerged from the Ministry, which then required readjustment, or did not align with the frontline operational needs. Further, where there is a void, other entities develop their own way of working. This affects consistency across the sector, which can lead to mixed messages and inefficiencies. Examples included:

- Revised health care worker exposure guidelines (i.e. factoring vaccination on contact status of health care workers); the delay in these guidelines were seen by respondents to impact on workforce capacity, patient care and outcomes, including patient risk.
- Barriers were noted with distribution of personal protective equipment (PPE) to healthcare workers going into people’s homes, as it was out of line with the framework in place, which itself was out of date. A workaround was needed until policy could fill the gap.
- The policy decision on differentiation between vaccinated and unvaccinated cases in isolation couldn’t be implemented in the rapid timeframe required, because of scale of flow-on effects (for example, MIQ beds, manaaki support, managing close contacts and technical changes).

Some sector respondents noted that there were occasions where they had been part of a combined team with the Ministry designing responses jointly, with successful outcomes; this was a clearly more preferred approach.

“Lessons learnt I would say would be the ability to pre-plan and think about some of those things before decisions are made, and engagement and connection with the sector to ensure that their knowledge, their experience, can contribute to the decision or the thinking and the planning at a Central Government level.”

Planning and engagement with primary care

A further concern was the lack of planning and engagement with primary care, and concerns were raised of a sector that had not been well-utilised for responding to COVID, despite their direct connection to the families enrolled in their services. At the time of data collection, a funding model was not yet in place for self-isolation, and this was seen as a key platform for building the primary care role in managing COVID through the minimisation approach. In its absence, there was seen to be a continued reliance on the overstretched public health workforce, whilst at its peak, as many as 4000

people were being actively managed in self-isolation. At the time of interviews, the Ministry of Health Care in the Community Framework was in its early stages of release⁷.

Short-term funding cycles

The nature of funding and appropriation cycles was a challenge noted by some respondents, one that was accentuated by the COVID response and the need to deliver services at pace. Service providers needed consistency of funding to deliver services and retain staff but were often forced to seek short-term funding solutions from multiple agencies. Some respondents highlighted the challenges of community providers, particularly Māori and Pacific providers, that grapple with six-month funding envelopes and services that are already committed, and which they maintain simply in the hope that funding will be found.

Looking to the future: Planning for COVID beyond the short-term

In the short-term, respondents noted a need for stronger locally-led solutions, and building system-wide responses nationally. In the medium-term, planning for managing COVID alongside ongoing system demands will be needed.

A clear strategy is needed for COVID within the context of business-as-usual and other health system pressures, particularly minimisation and recovery.

FUTURE FOCUSED THEMES and ACTIONS

Planning for managing COVID in the short-term

Looking ahead, respondents raised a range of issues to consider in the short-term:

- Enable locally-led and regionally-enabled solutions, reducing the reliance on solutions coming from the Ministry. Many sought a clear regional response structure that is less centrally-driven, and which would enable tailored local responses.
- Refine partnering processes in place with the sector to ensure more collaborative policy and operational development for future emergency responses.
- Support regions and DHBs nationally to continuously prepare for a national system of COVID response; at the early stage of interviews, there was thought to be wide variation in approaches across the country. However, subsequently national and regionally-based response structures were in place in time for the holiday period, with a national SRO appointed.
- Ensure all parts of the system are working together, so that smaller population areas can benefit from a system-wide response.
- Maintain some level of ongoing support for MIQ; new variants of COVID will likely arrive from overseas, and there was a view that if New Zealand exits this space it will be difficult to re-establish capacity.

⁷ New Zealand Ministry of Health (2021) 'Care in the Community Framework'. Wellington, New Zealand.

Managing both COVID and other health sector continuity in the medium term

There were diverging views between what is seen as COVID, and what is seen as business-as-usual (BAU). There was seen to be a role of dedicated leadership in the non-COVID space to enable what is seen as BAU (i.e. non-COVID) work to continue. However, COVID is not just a COVID Directorate issue, it has ramifications across the health system and more broadly, and is effectively part of BAU.

Decisions about relative priority are needed so that resources can be optimised for key areas of activity, maintained at the same levels, or scaled back.

In the medium-term (six months or more), several respondents noted that a plan is needed that takes into consideration the other functions and pressures of the health system at an operational level in order to plan for and manage COVID over the next 6-12 or 18 months while still maintaining other health sector continuity. In this way of thinking, COVID is expected, planned for, prepared for and the system responds accordingly; in the same way that there are influenza and winter illness planning.

Some additional actions of note were:

- Plan for what minimisation means in practice for the health system, looking beyond the COVID Protection Framework, and involving people in developing policy with technical expertise and knowledge of the practical realities.
- Regain focus on the downstream impacts on the health system and affected populations (such as planned care and immunisations).
- Develop dedicated response plans for populations with particularly acute or multiple vulnerabilities, which are nuanced to provide efficient, effective and equitable health outcomes.

Longer-term planning

Respondents noted that this is a system under pressure, and that throughout the system people are working very hard to achieve the best outcomes for New Zealanders. The Ministry needs to develop and communicate a clear strategy from planning/policy to operationalisation, with consistency nationally while allowing for regional flexibility and responsiveness.

“It’s easy to focus on any changes we need to make to activation and response systems; actually, the change we need to make is to build better planning systems so that the response and activation systems are better able to respond.”

Some of the areas noted were:

- Consider COVID planning in context of BAU and other health system pressures. Emergence of variants (such as, but not limited to, Omicron) will be an ongoing challenge, and need to be planned for. Alongside this, there is a need for planning for ongoing mobilisation of the COVID vaccination infrastructure to address gaps in areas such as measles catch-up and childhood immunisations that are well below optimal levels in some areas.
- Plan now for what COVID-19 system recovery entails, looking beyond different variations of responding.
- Continuously strengthen communication and coordination between central government agencies (MBIE, MSD, Education, Ministry of Health, Ministry of Justice) as well as with DHBs/local entities.

5. Equity responses to Māori, Pacific and other priority populations

Determination to succeed in a challenging landscape

Within a very challenging landscape, there were some significant gains throughout the Delta approach. A substantial investment in Māori and Pacific health response capability was made available, and distributed quickly.

Generally speaking, Delta fuelled a more permissive and responsive environment to do things differently, and for Māori and Pacific providers to take a whānau-centred approach.

Across the response, many highly skilled people are committed to doing the “right thing” for Māori, Pacific, and disabled communities.

The Māori Health Directorate advice maintained a strong focus on Te Tiriti o Waitangi and equity, and had a proactive role in supporting all planning discussions and supported good working relationships between the Ministry, Iwi and Māori and Pacific providers.

Significant investment in Māori and Pacific COVID responses

Substantial funding was allocated to Māori and Pacific providers in the immediate Delta response, which was distributed quickly. This included:

- \$36 million for the Delta outbreak response to Māori in September 2021.
- \$120 million for the Te Puni Kōkiri-led Māori Communities COVID-19 Fund.
- \$26 million allocated to Pacific health and disability providers.
- \$10 million allocated to transitioning Pacific communities to the COVID protection framework.

This was in addition to \$136 million allocated by the Ministry’s Māori Health Directorate and the COVID-19 Vaccination and Immunisation project to build capacity for Māori communities. These covered operational costs, and additional staff and training to manage demand and other costs.

The Delta response fuelled opportunities to do things differently, and to some extent, more efficiently. On the whole, the Ministry responded with urgency and gave “green lights” to providers to redirect funds as required. Contracting processes improved with “money getting out the door faster.” These built on lessons from a mid-2021 review by the Māori Health Directorate which noted the importance of more permissive contracting arrangements.⁸ However, it was noted by some respondents from Māori and Pacific contexts that the effort required to bid, and be approved, for funding specific to pro-equity Māori and Pacific activities was highly demanding for Māori and Pacific teams within the Ministry and in the sector.

Some respondents spoke highly of the Ministry of Health in response to Māori, particularly regarding dedicated funding to support Māori providers. A few respondents noted it as the largest centrally funded investment of Māori providers in this decade. The Ministry also extended contracts to new

⁸ Ministry of Health. 2021. 2021 COVID-19 Māori Health Protection Plan. Wellington: Ministry of Health.

providers including hapū and smaller organisations. These providers extended outreach into communities, and access to whānau that services often fail to reach. They helped coordinate non-vaccinating activities and supported activities like getting kai packs out to whānau.

“I think the strength has been the ability to be able to directly commission Māori and Pacific providers has been great. That’s what we need more of, and that’s, hopefully, where we will be heading to in the new system.”

Māori and Pacific providers as first responders

A consistent and strong theme has been the significant contribution of Māori and Pacific providers as part of the Delta response. Many respondents spoke about the valuable role Māori and Pacific providers played as "first responders" and providers of pro-equity approaches. Of significance are the kaupapa Māori and Pacific whānau-centred approaches, tailored to their communities and providers as advocates for improved access by reaching out to whānau, and taking services into communities.

“Māori providers and iwi have behaved quite differently to how the government has responded, because they’ve actually actioned and stood up things a lot faster. So, they’ve been a lot more protective and proactive.”

To be better positioned to respond to the needs of whānau and their communities, Māori providers prioritised, and have been able to access, COVID vaccinator training. This has significantly increased Māori provider workforce vaccinator capacity. This was beneficial for their Delta response but has longer term benefits for the booster and 5 to 12 years vaccination campaigns. “The development of kaiawhina as vaccinators where 53% of that group was Māori and 17% was Pacific” was considered particularly valuable. As one respondent noted, this was “an absolute stunner for equity and workforce.”

Equity responses as part of Delta

The Ministry has a stated commitment towards equitable health outcomes for Māori, Pacific, disabled, and other vulnerable communities experiencing disadvantage. Despite the acknowledge shortfalls of the overall COVID response and Delta as part of that response for Māori and Pacific, most respondents were able to identify some areas where an equity approach was evident.

Many respondents, from within and outside of the Ministry, spoke passionately about equity as a priority. Examples cited include the Ministry supporting the establishment of two equity advisory groups: the Lived Experience Advisory Group and the Equity Advisory Group. These groups acknowledge that solutions were often developed by people with no lived experience and outside of the affected communities. Although these groups are still evolving and establishing, they were seen to be a step forward in ensuring the community's voice and those impacted most directly by the response contribute to policy and operational decisions.

Across service delivery, some respondents recognised the work of DHBs, community emergency housing, and residential care, particularly within the NRHCC. In collaboration with the local Māori and Pacific communities and providers, Ministry and sector personnel linked with groups traditionally harder to reach, including gang networks and the homeless.

Throughout the response, what was clear to respondents is that equity responses, particularly for Māori and Pacific, require solid relationships and partnerships and the ability of the Ministry to trust

providers and give up power to enable locally led solutions, tailored to context, community and resources. Where there were trusting relationships between Ministry, and Māori and Pacific providers before the outbreak, responses had run more smoothly. These tried and tested relationships enabled providers to deliver to their communities. However, it was reported to be more challenging to gain traction where relationships had been problematic or haven't existed.

To get information and support out as quickly as possible, many respondents shared how the Ministry adjusted procedures to improve advocacy for communities, such as Cabinet papers that were developed within a week. Respondents also commented on the Ministry and sector ability to change traditional ways of service delivery with the response. This included working with people who put their hands up to lead activities in their communities. For example, testing units were sent to marae and supported housing sites. In some places, there was a more joined-up approach. In Hauraki, at a local marae, testing and vaccination units stood side by side, with MSD support also available.

Māori Health and Disability Services Directorates, and the Pacific Health Team

Overall, respondents spoke positively about the Māori Health Directorate, the Pacific health team and the Disability Services Directorate, and their commitment to pro-equity responses. They have overseen relationships with Māori and Pacific communities and continued their efforts to provide support and reassurance. They worked with iwi, Pacific community and churches, the disabled community, and mental health providers.

Many respondents identified Māori and Pacific leadership within the Ministry as one of the critical strengths of the Delta response. They have small teams with limited capacity but carry a significant portfolio across COVID, as they work to create a clear line of sight, within the response, to Te Tiriti and equity.

Within the Delta response, there are strong working relationships across the Māori Health Directorate and Pacific health team, where they supported each other in their pursuit for equitable outcomes for their people. There is a level of collegiality built on shared experiences and understanding. More generally, collaboration occurs between Māori Health Directorate, the Pacific health team and other Ministry directorates.

Māori Health Directorate leadership met regularly with Ministers and iwi leaders to discuss and resolve issues within the response, and influence policy to reflect a pro-equity stance. The Māori Health Directorate reviews all operational guidelines to ensure consistent decision-making and response to Māori communities. Despite advice not always being taken on board, some respondents identified areas where an equity lens was applied, including the successful vaccination outcomes of kaumatua (65 years and over), and working with iwi and Māori throughout the approach.

Most respondents indicated that the Māori Health Directorate's role in engaging directly with iwi and hapū bypassed bureaucratic structures and significantly changed the response's fidelity. Several respondents noted the positive feedback from Māori providers and clinicians around communications from the Māori Health Directorate, and that it helped develop their responses to the community.

“Dial back the public health expertise and dial up the cultural competence, that’s what got us on top.”

The Pacific team worked well within the Ministry, drawing on knowledge of their Pacific families and communities. They developed a national response that supported the Pacific communities in Auckland, connected directly with Pacific families who Delta had impacted and with Pacific church ministers' support, and convened meetings, including outside of business hours, to increase understanding and enable communities to lead their responses.

Further, they understood that connecting with Pacific families in their communities was not only the right thing to do, but was the most effective approach to provide support as part of the Delta response. The Pacific response components were highlighted as "agile and coordinated", including having someone to attend the stand-ups in the region and then communicate that information to Pacific communities.

Challenges in delivering a pro-equity response

Despite the strengths and successes noted in the previous section, the Delta response was not seen to have equitably responded to the needs of Māori and Pacific people, and other vulnerable populations. Some respondents noted that the overall design of the Delta response was not based on a pro-equity perspective, and reinforced existing barriers and inequity in the health system. Many respondents acknowledged that the strengths of the response in terms of equity were attributable to the Māori Health Directorate and Pacific health team and especially to Māori and Pacific providers. The overall sentiment of respondents was that stronger pro-equity accountability is needed to protect Māori and Pacific communities and give effect to Te Tiriti o Waitangi and the partnership between Crown and Māori.

Limited integration of advice and cultural intelligence

Although the Ministry endeavoured to focus on vulnerable groups, equity was not seen to be front and centre. Many respondents shared feedback on situations where sector advice and cultural intelligence were not taken on board by the Ministry.

“[The response] should have been developed with equity at its core, and if we got that part right, it would be right for everybody.”

As a result, some respondents felt that the Ministry essentially tacked on equity after the response team developed decisions and plans. Respondents frequently spoke about the vaccination rollout as a poor example of applying an equity approach. They were concerned that:

- The Ministry did not take on Māori advice pointing to the need for an ethnicity-based/whole of whānau approach.
- The vaccination programme did not reflect the Ministry immunisation team experience or knowledge.
- Consultants had developed the vaccine programme and did not incorporate advice or cultural intelligence.

Responsibility for equity within the response was primarily the responsibility of a couple of small teams. Capacity issues meant that the Māori Health Directorate and the Pacific health team could not

influence and embed equity across the entire COVID response, and at times, felt disconnected from the response. Respondents reflected that without the necessary leadership and resources to drive equity within the Ministry, policies and responses did not always reflect the needs of Māori and Pacific. Nor did they respond to the legacy issues within the healthcare system or provide ways to alleviate them.

Despite a stated commitment to equity, some respondents were of the view that the Ministry does not have equity embedded as part of the mainstream organisational culture.

“The Ministry may have (a stated commitment to equity), but it certainly wasn’t visible to me what their equity led approach with planning was.”

“With the right approach, everybody can access healthcare and then it’s just speed and resource. If you distract from a pro-equity approach, you spread resource too thin to achieve inequity.”

Equity appears to be the responsibility of a small number of staff, with limited resources and influence. Respondents shared that strategic decisions are made daily within the Māori Health Directorate and Pacific health team, as to which discussions they can participate in due to limited staffing resources and high demand. As a result, some Ministry teams develop policies, documents and communication without cultural input. Within the COVID-19 Directorate, a single Chief Equity Advisor is responsible for pursuing equity; feedback indicated that this resource was insufficient. As a result, several Ministry and sector respondents felt that a lack of robust cultural intelligence and guidance hindered the Delta response.

The toll on Māori and Pacific staff

Although there appeared to be some motivation to embed Te Tiriti and equity within the Ministry and sector, there did not appear to be a clear understanding of how to achieve this. As a result, Māori and Pacific expertise was heavily relied on to build equitable solutions into the response. For Māori and Pacific staff, the responsibility of producing an equitable response weighs heavy on their shoulders. They knew that their whānau will continue to be significantly impacted by COVID responses that do not have a pro-equity approach.

“Everyone’s impacted but we’ll be burying our loved ones and that’s the difference in why we do what we do. We do it for that. To give back to our people.”

Lack of a pro-equity response

Many respondents referred to the rates of infection, hospitalisation, and vaccination rates within Māori and Pacific populations, as evidence of a response that was not designed nor implemented with pro-equity as the overarching strategic feature. Some respondents expressed strong feelings about Māori statistics reflecting a racist system that privileges non-Māori.

The Delta response was seen to exacerbate pre-existing disadvantages in the system, especially for Māori and Pacific, and also highlighted the systemic issues within the Ministry and DHB structures and processes. By not prioritising Māori and Pacific throughout the response, particularly the vaccination programme, respondents pointed to the need for the subsequent “catch up” work. One of the impacts identified by respondents was the lower vaccination rates for Māori. Some respondents saw

lower vaccination rates as a direct result of a sequenced, age-based approach that did not consider the younger age structure of the Māori population.

BAU systems and processes

Many of the respondents believed that operating in the same way within the same structures only exacerbated the challenges facing Māori and Pacific communities. A further concern for several respondents of the Delta response is the long-term impact of COVID on the future health status for Māori and Pacific in terms of other health and wellbeing needs (e.g., childhood immunisations).

Generally, respondents felt that Māori and Pacific providers were better placed to connect with their communities. This contrasted with the perceived over-reliance of DHBs in implementing the response, particularly the vaccination rollout. A few respondents mentioned that delivering through mainstream primary healthcare proved to be less successful for Māori. This was because Māori are less likely to access healthcare through GPs, and there are little or no accountability measures or controls within the primary health system to either build equity or improve equitable outcomes.

Data analysis and reporting

Some respondents mentioned that the Ministry did not analyse data appropriately to support Māori and Pacific responses in the community. They frequently cited the lack of ethnicity-specific data or data concerning vulnerable cohorts, particularly in the early stages of the response. As an example, at the time of interviewing, one respondent noted that there had been eight deaths due to Delta, seven of whom were Māori. Some respondents noted that this level of detailed mortality data is not covered regularly by reporting. The prevalence of COVID among Māori and Pacific people remained high: as of 20 December 2021, 46% of all cases and 39% of hospitalisations were Māori; and 29% of cases and 35% of hospitalisations were for Pacific people.⁹

A lack of specific data concerning Māori and Pacific people, and the disabled community, impeded the planning and delivery of the sector, who, without clear information, felt they could not provide the needed nuanced, equitable response.

Te Tiriti and equity in practice

Within the Ministry, despite well-intentioned personnel, there appears to be a gap between the principle and operationalisation of equity. For some respondents, it was about responding to Tiriti obligations; for others, equity was about addressing racism in the system. Also, several respondents noted that there was little visibility of disability and other priority populations (e.g., homeless).

Based on the apparent differences in health for Māori and Pacific in access, engagement, and outcomes, many respondents commented on the merit of an ethnicity-based approach, particularly in the vaccination rollout. Overall respondents noted that the Delta response to Māori and Pacific communities could have been scaled up much sooner, particularly with regard to vaccination.

Tracking vaccination rates by ethnicity

Figure 3 on the following page details trends in vaccinations for Māori, Pacific people, and non-Māori non-Pacific by mid-December 2021, at the conclusion of the interviewing period. At the start of the Delta outbreak, the fully vaccinated rate for Māori was around 8% lower than the non-Māori non-

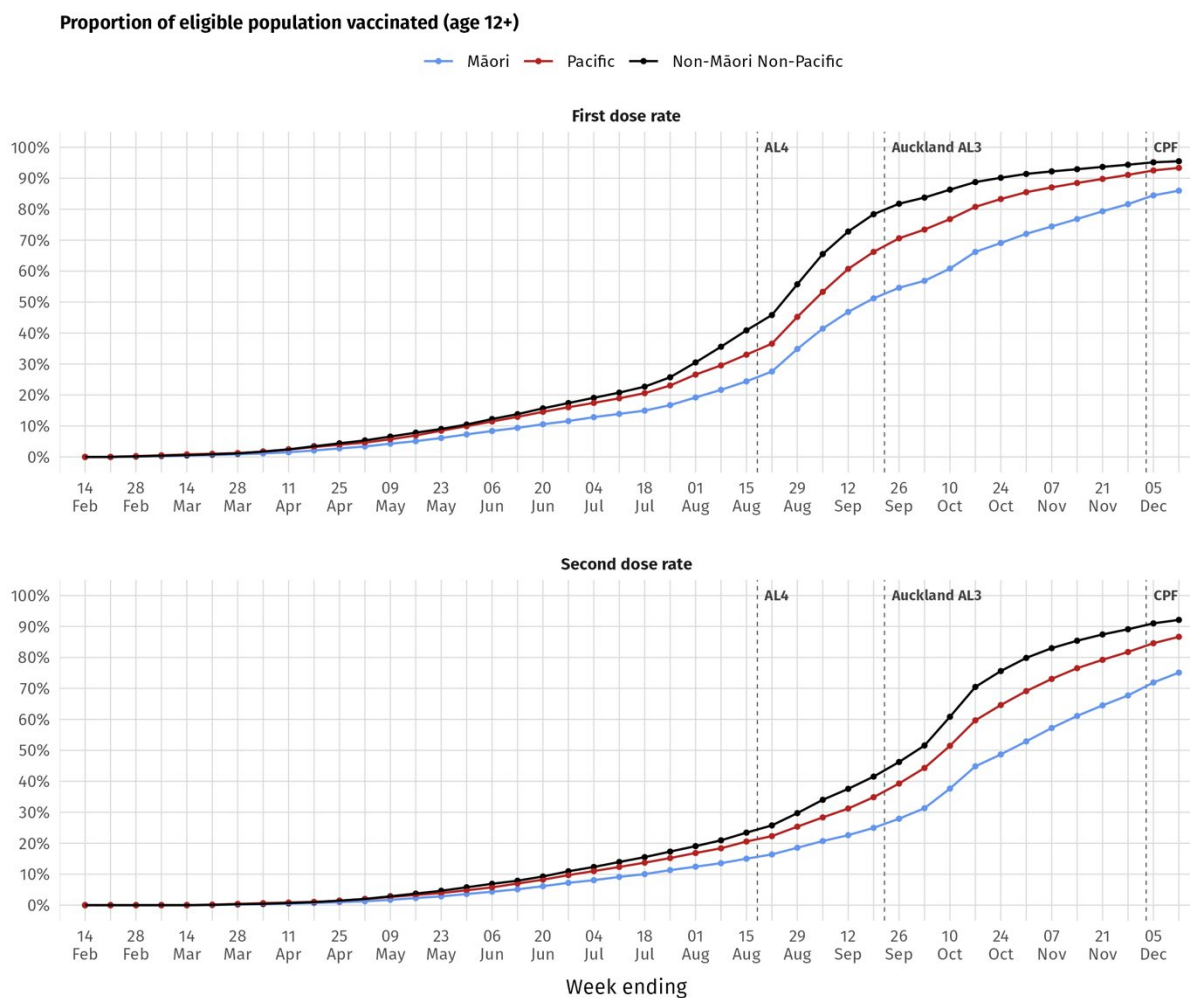
⁹ <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-case-demographics#aug-2021>

Pacific rate, and the Pacific rate was around 3% lower. By the time Auckland went to Alert Level 3 these gaps had widened to 17% for Māori and 7% for Pacific.

By mid-December, available figures indicated gaps remained for Māori (despite overall gains in vaccination rates), with fully vaccinated rates 17% lower than non-Māori non-Pacific, and a closing of the difference for Pacific, at 5% lower. Rates among older Māori and Pacific people were comparable with non-Māori non-Pacific (aged 50 years and older).

At the time of submission (March 2022), vaccination rates were substantially more aligned between ethnic groups, with 87% of Māori and 96% of Pacific people double-vaccinated.

Figure 3: Māori, Pacific and non-Māori non-Pacific vaccination rates, 17 December 2021



Source: Ministry of Health data (excludes booster rates)

Dominance of clinical models and mainstream approaches

The majority of respondents acknowledged the challenging nature of the Delta variant and the system's legacy issues, all of which impacted the ability to develop and implement an overarching equity approach. Respondents from within the Ministry and the sector, shared how a clinical lens took precedence in the Delta response, and that it was a struggle to align with the more significant needs of whānau, including social and cultural needs. However, Ministry and sector respondents have seen that responding to social and cultural conditions is critical.

“So we have over 1,000 whānau isolating at the moment. The biggest complaint is hunger in a first world country like New Zealand... We've put the rules in place for whānau to isolate. We need to make sure they've got the basics to actually survive it.”

Although unintentional, many respondents commented on the inherent assumptions that drove response planning – and the mismatch with the reality of some Māori and Pacific whānau. These include that people are registered with and can access GP clinics; that people have homes to self-isolate in; and that there is access to a phone, internet, and power. Similarly, a few respondents mentioned how in rural, isolated communities like Northland, whānau live off the grid, and there are no GP clinics available with easy access. Also, in smaller communities throughout the country, GP clinic books are closed, which means having transport to drive to larger centres to access healthcare.

Respondents across the Ministry and sector also acknowledged the historical lack of responsiveness to Māori and Pacific needs. As a result, Māori are less likely to access mainstream services because of distrust with the healthcare system. Based on poor experiences and distrust in the health system, many respondents shared how people were reticent about coming forward. This was apparent as Delta infiltrated more communities around the country, vulnerable populations, and those deemed “hard to reach” like gangs and homeless.

Without a pro-equity approach underpinning and guiding the Delta response, many challenges arose, impacting the ability to give effect to Te Tiriti and respond to the needs of Māori and Pacific communities. Many respondents saw the response to Māori and Pacific as a workstream rather than central to the whole strategy, with equity subsequently tacked on. Respondents uniformly agreed that prioritisation of Māori and Pacific needed to occur in planning.

“The trouble with this approach is that we just double down on inequity.”

“I think our system we set up to respond to Delta works really well for 75 to 80 percent of the population, and particularly if they're well-informed, connected via internet or phone or what have you, but for the group that Delta got into, I think some of our elements of response were not good.”

Many respondents felt that modelling was based on a whole population approach and lacked the predictive capacity needed for Māori and Pacific communities. This contributed to a response that did not prioritise Māori and Pacific. This was particularly so in the early stages of the outbreak and sequenced vaccination rollout. These challenges were compounded by the mainstream design that failed to consider the existing inequities experienced by Māori and Pacific communities. The overall feeling amongst many respondents was that the response was focused on servicing the majority and fell short of meeting the needs of Māori, Pacific and other vulnerable communities.

In relation to the disability sector and our most vulnerable (homeless) respondents commented on the lack of visibility for many people in these groups. There is a sense that the Ministry could have tailored the response better to ensure that these groups were among the most protected.

Mixed success for the disabled community in the Delta response

Interviewees who provided perspectives on the COVID response for disabled people and their whānau noted that in the early stages of COVID in 2020, a response to COVID was developed and implemented that was co-designed with the disability sector. However, the consultative mechanisms were subsequently stood down, and were only belatedly re-established for the vaccination programme. Interviewees noted that the COVID Directorate undertook very little engagement directly with the disability community in the response to Delta; at the same time, the Disability Services Directorate is primarily focused on funding disability support, not on health services provision to disabled people.

It was noted that the greatest threat to disabled people was not the border, but other people in the community. There was seen to be immense fear of COVID within the disabled community, with reports of individuals isolating by themselves and reducing their ability to access health services. Some hard-won gains in PPE requirements, particularly mask wearing, prior to the Delta onset were subsequently vindicated as Delta unfolded. In a setting where disability support workers are often in their client's homes for long periods and in very close quarters, care workers weren't required to wear masks unless they made an assessment of symptomatology. The requirement for mask wearing under Delta provided a layer of protection that was much-needed.

A further positive outcome was the brief introduction of flexible funding where disabled people and their whānau were receiving personalised budgets via the Ministry of Health¹⁰, something which had been advocated for decades and which was able to be introduced in response to COVID.

The vaccination programme in the Ministry was noted by an interviewee to have made important steps in engaging the disability community and designing approaches that were responsive, and working through disability providers. Monitoring was set up to track vaccination rates, connections were made within the community and a working group was established. The vaccination programme learned and adapted, and took feedback from the community. As a result, vaccination rates as at November 2021 were comparable to the non-disabled population: 90% of disabled people had received at least one dose of the vaccine, compared to non-disabled (83%); 84% of Māori disabled and 85% of Pacific disabled had at least their first dose, compared to Māori (74%) and Pacific (79%) non-disabled people.¹¹ Lower vaccination rates are evident for those with complex needs, and those with hearing and remembering difficulties.

But these gains were counter-balanced by a view of a 'one-size fits all' approach to protecting the New Zealand population, which another interviewee argued overlooked the needs of disabled people, and which reinforced existing inequities in the health system.

¹⁰ Flexible Funding is a core component of the Enabling Good Lives approach, however not all disability supports are fully realising this component as yet.

¹¹ Social Wellbeing Agency. 2021. Analysis: COVID-19 vaccine uptake for disabled people. Social Wellbeing Agency Factsheet. Note that this data was gathered using COVID-19 vaccine records matched with datasets from the integrated Data Infrastructure (IDI).

Outside of vaccination successes, respondents indicated there were few if any nationally consistent or available protections established for disabled people specifically, and a general lack of policy and arrangements to meet the needs of disabled people. This included a lack of home-based testing, inaccessibility of testing, lack of accessibility of MIQ facilities for disabled people, and accessibility of vaccination settings. Despite expectations, a disability-specific communications campaign was not co-designed with the community and was instead competitively tendered to deliver a range of uncoordinated activities.

From the perspective of one interviewee, profound human rights issues were raised by the pandemic response, including significant restrictions placed on disabled people in rest homes, prompting complaints to the Health and Disability Commissioner.

Calls by disability advocates to collect data specific to disabled people in the Delta response appear to have been unheeded, and as a result we understand there is no systematic collection of disability status in COVID response mechanisms, and little way of tracking the extent to which responses are equitable.

Ultimately, following advocacy by Tatou Whaikaha, a disability advisory committee, a COVID disability plan was developed at pace to provide a framework for meeting the needs of the disability community. However, against advice, the response was delegated to DHBs to implement, in a context where disability providers are generally contracted directly by the Ministry. We were advised that DHBs, with little involvement in the disability community, developed their own responses without alignment to the national plan and no national consistency. Furthermore, disability advisory organisations were not able to tell the community what they could expect as there was no clear indication of what supports and assistance were available.

As the time of interviewing, it was hoped that the COVID-19 Care in the Community framework will be able to connect positive cases of COVID in the disabled community to a Disability Connector, Kaitūhono / Connector as a primary point of contact, but this is in early stages of implementation.

Looking to the future: Embedding a pro-equity response

As stewards and kaitiaki of the system responsible for protecting Aotearoa, the Ministry can make immediate to long-term changes to support Te Tiriti o Waitangi and equity. These changes should be made in collaboration with Māori and Pacific providers and the wider sector and informed by ongoing learning and cultural intelligence. There should be a clear line of sight to Te Tiriti o Waitangi.

FUTURE FOCUSED THEMES and ACTIONS

Short-term actions

In general, the respondents commented that improving equity for Māori and Pacific communities throughout the response requires strong Māori leadership in decision-making positions and the Ministry's willingness to apply essential advice and learning from the sector and Māori and Pacific providers.

In the main, at least half the respondents noted that to improve systemic inequities; there has to be a realisation that 'one size does not fit all' and then plan accordingly. Enabling Māori and Pacific people to design, develop and lead their approaches was also seen as critical. Many respondents identified a more joined-up collaborative approach was needed between Ministry, the sector, and Māori and Pacific providers. A few respondents expressed the importance of shifting the power to the people who have the "right" knowledge, skills, and ability to connect with Māori, Pacific, and people with disabilities. This change would also involve sufficient resources and funding for implementing future responses.

There were several specific actions identified across the respondents to alleviate the impact of Delta and sharpen the equity lens within the approach. These included the following short to immediate actions:

- Use ethnicity data to inform the continued rollout of the Delta response and support decision making in terms of equity for Māori and Pacific communities.
- Implement a whānau centred / pro-equity approach for upcoming vaccination rollouts for 5-12 years and booster programmes.
- Complete a more comprehensive review and analysis of the impact of COVID-19 within disadvantaged and vulnerable populations.
- Increase staff capacity in equity advisory teams.
- Dedicate a proportion of all funding allocated to Māori and Pacific-specific responses for future responses.
- Gather disability-specific data to inform planning and responsiveness.
- Co-design future responses with the disability community; there are already pre-existing groups that have the skills and experience to advise the Ministry on how to respond to ensure an equitable response.
- Ensure comprehensive and consistent support services are available to disabled people and their whānau, including Kaitūhono/Connectors in the continued response to COVID.

Medium to long-term actions

Proposed medium to long-term actions centred around the following key actions:

- Embed a pro-equity culture within the Ministry with clear actions and responsibilities for all staff who will act as proponents and champions. Increase Māori and Pacific leadership within the Ministry to influence decision-making. Also, ensure that non-Māori Ministry staff are aware of the equity challenges within the system and measure the extent to which policy and responses address inequities.
- Build cultural intelligence across the whole of Ministry and establish a shared understanding of what equity is and how it can be actioned in the community with Māori, Pacific, and people with disabilities.
- Develop equity-based success indicators for future responses to variants of COVID-19 that can guide both the Ministry and the sector as they plan responses for Māori and Pacific communities.

6. Workforce

Key Strengths

Across Ministry and sector stakeholders, there is a clear positive intent and willingness to deliver the best response possible in a deeply challenging environment, with an overarching goal to protect and respond to the needs of the community.

Dedication and commitment

A healthy and well-functioning health system requires the dedication of all its professions and disciplines. An overwhelming theme was the dedication of nurses, doctors, allied health, unregulated workforce, and a wide variety of others who are the heart of the operational delivery system, including kaimahi and staff at Māori and Pacific health providers. This feedback also extended to the wider workforce that supports the frontline at local, regional and national levels (such as managers, leaders, analysts, and commissioners).

“There’s a lot of individuals within a big system that are trying to do the right thing.”

Within the Ministry, the responsiveness and support of the Executive Leadership Team (ELT) led to many teams feeling that they had the information and tools needed. Many respondents spoke of the dedication and responsiveness of individuals, many of them named directly, within the Ministry who work constructively to support the sector, within a system that presents multiple challenges.

Māori and Pacific providers

The strength and responsiveness of Māori and Pacific health providers in primary care was noted, especially in the Auckland region as the Delta outbreak rapidly expanded; this was pivotal to ensuring a pro-equity response to meet the needs of Māori and Pacific communities. This included both frontline service delivery and leadership providing information and advice to inform system responses. Fuelled by Delta, there was a significant workforce development of Māori vaccinators in the Māori provider sector and that will have long-term dividends, especially if the health sector looks to expand scope of practice in this arena.¹²

“One of the things that we’ve been doing a lot of in our part of the country is growing the workforce within our iwi providers. And these are the sorts of skills that you need, around management of a pandemic in the community, that are exactly right up the alley of those workers within the iwi providers.”

Short Term Capacity Development

The exacerbation of ongoing workforce capacity issues was partially mitigated through the Ministry of Health’s work with Technical Advisory Services (TAS) in redeploying workforce into surge areas (Auckland Region). Additional capacity development noted during some interviews included investment into Māori and Pacific workforce development (such as non-regulated workforce

¹² The COVID-19 Māori Health Protection Plan notes that note that 49% of participants in training for COVID-19 vaccinators were Māori, and 11% were Pacific.

vaccinators), and the Ministry of Health leverage that enabled the addition of 300 managed isolation and quarantine spots for health professionals coming to New Zealand from overseas.

Workforce capacity challenges

Historic workforce challenges were exacerbated by the sudden demand placed on the system to respond to COVID and the Delta surge. These were particularly noted by DHB respondents. Widely raised workforce concerns were capacity, retention, capability, and exhaustion.

Workload pressures

The workforce risk at both an individual and a systems level is notable, as the workload and pressures were seen by respondents as unsustainable. A common theme of interviews was simply that the health workforce is exhausted, within both the Ministry and the wider sector, and significant staff turnover is becoming evident. Feedback indicated that the health system workforce felt at times like they are losing, not making enough progress, and are becoming less resilient (from frontline through to management and leadership).

“We’ve got real risk points ..., DHBs have got really tired people and we’re managing the balance between maintaining the appropriate staffing levels to respond to but keeping enough people off to be able to manage the wave that we’re going to see next year, so ... the workforce beyond COVID is a big thing that we really need to be focussed on.”

The level of individual distress was noticeable throughout the course of the review. The system continues to struggle with workforce capacity, and while there was activity that mitigated some of the issues (e.g. redeployment, use of non-regulated workforce, overseas recruitment), those actions did not meet the size of the need at the time. Respondents indicated this will not suffice to increase the capacity and capabilities needed as COVID spreads further.

“We had something like 200 people wanting to come back to New Zealand [to] jobs within the health sector, and due to the process we got 53 that MBIE processed [to get into New Zealand]... a 25% hit rate on returning people.”

Ongoing demand

Workforce and system resources remain in significant demand and a key workforce concern of respondents was the pace, intensity and length of sustained COVID response service delivery. In Auckland, the public health response to Delta continued with an expectation of intensity that respondents believed was not sustainable in a minimisation framework. Outside of Auckland, DHBs and other health organisations were also operating at an increased pace, whether in elimination or in preparation for the potential surge of cases around the 2021 holiday period or as new variants emerge in the community. As this unfolds, redeployment of staff into other regions is unlikely to be an option as they will be needed in their own workplaces or communities, thus reducing overall surge capacity nationally.

Institutional knowledge

Some noted that rapid recruitment into the Ministry of Health resulted in some of the newly deployed staff, consultants and contractors not having awareness of institutional process, systems and learning. This has resulted in disrupted processes and inefficiencies that could have been avoided.

“To me, it doesn’t feel like they’re using the expertise they have inhouse. ... Like, we have a whole immunisation team here who do a phenomenal job but they brought in [consultants] to do the vaccine rollout, so all the issues we’ve experienced in previous vaccine rollouts, we experienced again, because nobody thought to talk to the immunisation team about things will happen like four or five months into it, how do we have a national register, how do people have proof they’ve had it?”

Looking to the future: Workforce

Future planning needs to be actioned, with both short and medium-term mitigation and planning alongside long-term capacity and capability planning. This extends into the primary care and cross-sector workforce who will be needed to support communities.

FUTURE FOCUSED THEMES and ACTIONS

Short and medium-term planning

In the immediate future, workforce capacity diminishment was a noted high-risk area to be addressed, including but not limited to COVID related stand-downs, resignations, retirement spurred by high risk, and immigration/travel restrictions. The Ministry of Health’s ability to leverage their governmental position was appreciated (such as obtaining additional MIQ spaces for health workers), though more of this influencing was seen to be needed in multiple areas to facilitate increases in workforce capacity across all professions.

In the short-term, respondents identified a need for the Ministry to:

- Develop a plan for workforce sustainability. The level of fatigue of the entire workforce, from Ministry of Health to frontline is of significant concern and plans will help people to see the light at the end of the tunnel
- Partner with DHBs and leadership to identify actions that will improve morale and resilience.
- Resource the primary care and cross-sector workforce to respond to COVID. This is inclusive of the welfare and wellbeing workforce that will be required for wrap-around responses that are supported locally. This is not only for potential outbreaks and surge response, particularly in higher-risk or vulnerable communities but for ongoing care and support.

“I hope that ... and especially with the reforms... that we put a particular emphasis around getting workforce we need in this country. You know, we need to really get in there and do better at training Kiwis to work in our health system, particularly Māori and Pasifika. And put the supports around to make that happen, so we’re not caught out again by the situation that we’ve been in.”

Longer-term

Respondents noted that the current workforce issues are longstanding, and have been further exacerbated during the COVID response. Most of these leaders noted that longer term workforce planning and a cross-sector response is needed to support the health and social welfare systems as New Zealand moves to learning to live with COVID as an endemic disease. The need for a national workforce plan, strategy and investment were noted as critical to the longer-term success of the managing COVID on top of the other functions of the health system. With a highly constrained ability to bring in overseas workforce, growing local capacity (particularly Māori and Pacific workforce) was noted as essential in this planning.

“Workforce planning has sat at a local level, rather than a very clear national investment policy planning function, and that needs to change in the future. So, there is an opportunity to have a really clear long-term workforce investment strategy.”

7. Communications, information sharing and learning

Information and communications successes

Many strengths were seen in the channelling of information and communications from the Ministry, particularly in sharing intelligence and data insights, public communications, and the regular check-ins with the NRHCC team in Auckland. Sharing learning from the Auckland experience to support planning in other regions is noted as a key goal for future national success.

Communications and information sharing out to the public from the Ministry was described as a strength, especially for non-Māori non-Pacific public. Respondents from Māori and Pacific contexts, both within and outside of the Ministry, identified communications to Māori and Pacific populations as a strength they brought to the response.

Strengths in information, intelligence and communications

The Ministry has assembled rapid intelligence and policy advice throughout COVID, and particularly so during the Delta outbreak.

- Science and Insights team in the COVID-19 Directorate, and the Office of Director of Public Health spearheaded significant work that informed decision-making.
- Shared workforce needs were identified, working with TAS and rallying DHBs to manage workforce requirements and issues.
- Intelligence was collected with real-time data-driven insights and responsive analysis
- Ministry regularly produced tailored reporting for key stakeholders.
- Communications to the general public on elimination were seen as highly effective.
- A solid base of systems and learning were in place from previous outbreaks.

The daily check-ins with NRHCC and the processes in place were broadly viewed positively, and many noted the value of individual relationships and communications between Ministry and sector.

The need to share learning and application from the Auckland experience more widely to support regional implementation elsewhere was noted as a key goal for many respondents. The ramp-up of staffing in Auckland using workforce from across the country has enabled some sharing and first-hand experience. However, there were concerns from a small number of respondents about the ability for the system to achieve this fully and sustainably, as local areas will need to prioritise focus on activities in their regions.

Respondents noted a clear intent to learn and adapt. The Ministry assembled rapid intelligence and policy advice throughout COVID and particularly during the Delta outbreak.

Sharing information with Māori and Pacific communities works well when it comes from Māori and Pacific teams

The Māori Health Directorate's strong relationships with the Māori health sector was perceived positively by respondents within and outside of the Ministry. Their regular pānui to DHBs and providers was seen as effective practice and demonstrated positive relationships with providers.

Respondents from Māori and Pacific teams valued having up-to-date information from Ministry colleagues to share with the sector and leaders.

Respondents working in Pacific contexts, both within and outside of the Ministry highlighted the importance of communications that reflected the language and culture of distinct Pacific communities. For example, public members of different Pacific communities were more likely to access services when there were provider staff on the ground that were First Language speakers to address any concerns.

Challenges to sharing information and learning

In the rapidly moving Delta response, information sharing and incorporation of iterative learnings was a constant challenge. Respondent feedback indicates in the early stages, the Ministry appeared to struggle in balancing urgency, accuracy and relevancy of information shared for its many stakeholders; however, this improved over time.

CIMS and IMT processes

Most respondents described the CIMS-based structure as fit for purpose. The daily IMT meetings and check-ins were seen as valuable way to get updates and important information.

However, many respondents from outside the IMTs and the COVID-19 Directorate, and outside of the Ministry, struggled to identify who had responsibility and decision-making authority. They spoke of a lack of clarity about who to talk to when they needed to clarify issues, who to escalate issues to and how, and who to influence. Auckland's insights and expertise in managing COVID were seen as undervalued in a system that was seen as Wellington-led and disconnected from the reality of dealing with COVID in a day-to-day level.

“In terms of the COVID reporting lines, knowing who's making the decision on what, and when that decision's going to be made, and who you need to talk to, and getting in touch with them, that was really difficult.”

Some respondents noted that the daily IMT meetings had a large attendance (30-100 people), which made it difficult to be heard or to influence the conversation. They noted that influence had to take place outside of IMT meetings.

The addition of the Health System Response and Readiness Planning Group (HSRRP) within the IMT to focus on the downstream impacts was seen with mixed results. On the one hand, the addition of this Impact Management Group demonstrated a recognition of the need to have oversight and responsibility for downstream impacts on the broader health system from COVID related and resultant actions and policies. On the other hand, it added to the confusion for the broader sector and was thought to create additional layers of decision-making that hampered progress.

Pressures of information provision in a climate of urgency

Respondents highlighted the persistent change and evolution of policy, operations and process throughout the response. This is somewhat understandable given the changing nature of COVID and Delta. However, respondents noted the pressure to provide timely, up to date information under extreme time pressure.

The information sharing and learning appeared to struggle initially to effectively balance urgency, accuracy and relevancy needs for its many stakeholders, but these improved over time. Respondents mentioned inaccurate data being used and shared because of extremely short deadlines, the use of data that was not fully representative of the population for modelling, and challenges accessing data from the Ministry. There were also concerns raised about misdirected and duplicated communications.

Public communications

Most respondents felt the communications and information sharing from the Ministry out to the public worked well. They acknowledged that misinformation was prolific, especially on social media, and the Ministry had a role in addressing that. However, the messages and delivery channels used by the Ministry were seen as less effective for Māori and Pacific populations. Respondents from Māori and Pacific contexts spoke of confusion on the ground about access, eligibility and options to access services, for example, when official messaging contradicted their previously developed plans for pro-equity activities.

Communications to sector

From the sector, there were mixed views between respondents on how well the communication, feedback loops and learning system is working. Overall, there was a more positive impression from those who were based closer to the central decision-making in Wellington. Those who are closer to the communities, whether in the sector or in the Ministry, identified communications and information sharing as a significant challenge respondents had to overcome. The Ministry overall was not considered to be as responsive as some respondents wished, particularly in turning around policy advice. In contrast, the Māori Health Directorate's strong relationships with the Māori health sector, including regular pānui to DHBs and providers, was seen as effective practice and demonstrated positive relationships with providers.

Some sector respondents felt that communications were unnecessarily secretive. Many respondents spoke of needing to use their personal relationships and networks to source information and updates. They inferred a lack of trust from the perceived secrecy, and that their feedback was not reaching higher levels. They also noted a lack of advance notice of significant developments. For example, there were instances where leadership learned critical information through public televised briefings, or only through meetings with Ministers.

Looking to the future: Effective communications to support a learning system

Respondents identified a need to resolve communication challenges, increasing trust, and building greater collaboration with the sector. This includes ensuring Māori and Pacific are involved in mainstream planning and decision-making. More broadly, there is an opportunity to strengthen internal communications, and to further refocus communications with the public.

FUTURE FOCUSED THEMES and ACTIONS

Actively involve Māori and Pacific in processes

Effective communications to support a learning system requires the right people at the table, with the right data and clear responsibilities. Respondents from Māori and Pacific contexts highlighted the need to rebuild trust. There is a need in the immediate future to implement changes in the communication loops to ensure Māori and Pacific peoples are fairly represented in planning and reporting. This includes ensuring colleagues from Māori and Pacific contexts, both within and outside of the Ministry, are at the decision-making table. This would reduce the need to use informal networks for official information, increase accessibility, and ensure communications that better meet the needs of Māori and Pacific communities.

Improve information sharing

The response to COVID and Delta in particular has been a multi-agency response. Respondents highlighted the urgent need for improved information sharing between central government Ministry and Departments. Some respondents identified a lack of awareness about processes, contact people, and responsibilities of partner agencies. For example, welfare was seen as the responsibility of MSD, but often fell to Māori and Pacific health providers to deliver. Māori and Pacific providers had multiple grants and funding opportunities available through the different government agencies, however, there were pockets of confusion and overlap of funding eligibility that Ministry staff needed to support providers to navigate.

More broadly, there is a need to build increased consistency of communications and intelligence across the sector. This includes ensuring official communications are clearly disseminated to operational leads across the sector prior to public announcements of policy changes. These communications require engagement from operational leads on the ground and colleagues from Māori and Pacific contexts. It would further reduce the likelihood of official national communications at odds with local messaging tailored to Māori, Pacific and disadvantaged communities.

Re-focus public communications

With the shift from elimination- to minimisation-focussed policy, learning from the Delta experience highlights the need to refocus communications and messaging with the general public. Some respondents highlighted the need to communicate the vision of this change and the implications for the general public and 'living with COVID'. Respondents noted the opportunity to craft messaging and supporting data to empower people and communities to take charge of their own health, with the provision of centrally-developed and locally-led health advice regarding how to manage illness at home. Subsequent to interviews this is becoming evident in the Care in the Community framework.

8. Strategic leadership

The strengths of leadership in the Ministry was noted by many respondents. However, decision-making and SRO structures were unclear to many. Fatigue is evident in multiple levels of leadership in the Ministry and sector.

Governance, stewardship and operations

The leadership of the Director-General throughout the COVID pandemic was noted positively by many, including for communication, dedication to the role, and incisiveness and grasp on the issues at hand, and maintaining a strong public health-oriented response. The responsiveness of ELT to their teams within the Ministry was also seen positively. The Office of the Director of Public Health was noted for providing critical leadership across multiple areas of policy. Leaders in the Māori Health Directorate, and the Pacific Health Team, were acknowledged for their connection with the sector and their advocacy for their communities.

“It is about public health not everything else. And being really steady and not bending under pressure. And that I think has been what has stopped a quicker escalation of cases.”

One perspective noted that the Ministry of Health ELT has been drawn into making operational decisions rather than governance and stewardship. At the same time, many respondents noted difficulties in identifying where decision-making was occurring. There was a call for a clearer distinction of the ELT role, and in some instances, a stronger SRO structure to enable decision-making and implementation.

We note that in advance of the holiday season, a national coordination structure for COVID activities was in place, that enabled national stewardship and governance, a SRO structure, a national coordination centre and four regional coordination centres. This provided a structure, process and identified leaders with responsibility for monitoring, reporting and coordinating responses on a daily basis.

It was also noted the fatigue that is evident across the sector and Ministry, and leadership in the organisation was no exception. Within the Ministry, some respondents called for clear points of pause and reflection, to build a more transparent, adaptive, learning culture within the Ministry, and one that works across directorates.

At local levels, the knowledge of the health needs in communities across Aotearoa were seen as being neglected in favour of Ministry-driven models and policy. There were calls for support for more locally-led initiatives within the broader stewardship role of the Ministry.

Looking to the future: Leadership

Greater clarity on responsibility and accountability was called for, along with giving greater weight to locally-led solutions. Increased attention to Māori and Pacific leadership, as well as those of other priority populations, was called for in a system that has historically struggled to meet key population health needs. Ensuring leadership, and the wider workforce, have the capacity to rejuvenate individually and collectively will help deliver a robust and adaptive ongoing response to COVID.

FUTURE FOCUSED THEMES and ACTIONS

Improve clarity regarding responsibility and accountability

In the short-term, there is a clear need for clarity on responsibility and accountability, related to who can make decisions at the Ministry and who is doing what. This includes quicker and streamlined decision making on resourcing to regions/ districts regarding release of funding overall and, particularly into areas of inequity, where people are being disproportionately affected by COVID. This is particularly important during outbreaks (or anticipated outbreaks) where quick responses are needed on the ground.

Resource workforce to ensure capacity to rejuvenate

COVID is likely to be a reality for some years to come. Ensuring leadership, and the wider workforce, are well-cared for and have the capacity to rejuvenate individually and collectively will help deliver a robust and adaptive ongoing response to COVID.

There is also a need for developing representative leadership and capacity, so that there is stronger representation in leadership and decision-making of Māori, Pacific and other priority communities.

Improve balance of central control and local innovation

There is a balance to be achieved between central control and local decision-making and innovation – as the system transitions towards minimisation and COVID management. There is a need for greater local flexibility and decision-making, as well as integration across currently siloed areas of the health and disability system; this fundamentally requires trust between parties as the foundation of a collaborative and collegial environment.

9. Conclusions

From the onset of COVID-19, New Zealand undertook an evidence-based and adaptive public health response that has saved lives and remains world-leading to this day. The Delta variant posed a significantly new set of challenges that demanded a multi-faceted response.

In the Ministry of Health's Incident Management response to the emergence and management of Delta, we can see clear strengths in the rapidity and scale of response, and the extent to which the entire health sector was mobilised. Well-established relationships and structures were in place, building on knowledge and expertise developed throughout the course of the pandemic. There was significant implementation and expansion of systems and capacity in dealing with Delta.

Policy responses such as lockdowns, vaccine mandates, development of the non-regulated workforce, and health worker prioritisation in MIQ were all important contributors. Substantial funding was allocated for Māori and Pacific health providers to meet the needs of people and whānau managing or isolating from Delta, and in the vaccination programme rollout.

A common concern of many respondents was the limitations of the Delta response in equitably meeting the needs of Māori, Pacific and other vulnerable populations. Other concerns were shortfalls in operational input into policy, lack of clarity in decision-making structures, and the ability of policy to keep up with operational decision-making.

Looking ahead, a critical challenge for the sector will be maintaining workforce capacity, and minimising fatigue and burnout, in the face of COVID-19 variants and ongoing business as usual health service delivery. Giving strength to locally-led solutions, providing clarity on responsibility and decision-making structures, and enabling greater sector input into policy, will all help to build trust and responsiveness across the system in the future.