ALL-OF-GOVERNMENT COVID-19 PRESS CONFERENCE: FRIDAY, 3 APRIL 2020

Dr Ashley Bloomfield: Well, kia ora koutou katoa and welcome to today's briefing. There are 49 new confirmed cases of COVID-19 and 20 new probable cases to report today. There have been no additional COVID-19 - related deaths, so the overall number of new cases is 71 and the new total in New Zealand is 868 cases. There are now 103 reported cases that we can confirm have recovered. Today, we have 13 people in hospital around the country, including one person in ICU. All those people are in a stable condition. From our lab testing numbers, we can report a seven-day rolling average of tests at just over 2,000 per day, and the total number of lab tests to date is 29,485. And a high of 3,446 tests were processed yesterday. We now have the capacity to do over 5,400 tests each day in New Zealand.

For the cases that we have information on, there's still that strong link to overseas travel, although it's just dipped below 50 percent—it's at 49 percent—as well as 33 percent who have links to confirmed cases. So far we have confirmed community transmission in just 1 percent of cases, but there is that 17 percent of cases that are still under investigation, and we would expect many of those to end up being confirmed as community transmission.

An update on the clusters: we now have 10 significant clusters—that is, more than 10 people who are infected from a single point-source—and those are in Napier, Wellington, Hamilton, Auckland, Bluff, Matamata, and Waitakere. The three biggest are the clusters in the Marist school in Auckland, that's 59; the Bluff cluster, which involves 53 people; and the Matamata cluster of 49 people.

A quick update on community-based assessment centres: those have been operating in some locations for the last couple of weeks, and we now have 62 in place around the country, as well as 45 designated practices or swabbing centres set up to handle testing for COVID-19. We've asked all DHBs to set up and start running their CBACs, as they're called, from this weekend, so we know where demand is strongest—and also so that we can just test the processes that those CBACs are running well, and they've got the testing happening and getting the swabs through to the labs nice and efficiently.

Just a little on recovered cases, and I was asked yesterday about the definition—just to clarify our current definition. So, I've had a look at this since yesterday's conference, and, actually, countries are taking slightly different approaches to this—not unexpectedly, given this is a novel disease. But those approaches are based on what is generally done for other, similar communicable diseases. We're continuing to watch international developments closely, and we're very much in line with Australia and many other countries here.

So the current criteria we're using for someone being confirmed as having recovered and being able to be released from isolation is that it is at least 10 days since the onset of their symptoms and at least 48 hours from being symptom free. That's the advice we have currently from our communicable disease specialists, and we'll keep that under close watch. In fact, the technical advisory group is meeting again today and will be reviewing that. So a negative test is not required for someone who is recovering at home from COVID-19 infection, which would generally be mild to moderate; and for someone who's been hospitalised, it's up to the clinician whether they choose to do testing prior to discharge.

In terms of the border, just an update on what's happening there. So yesterday, 300 people arrived into New Zealand, so you can see that the numbers are now much, much lower than they were even a few days ago. Those are all Kiwis coming in—there are no visitors coming in, so these are Kiwis returning to New Zealand. All people entering New Zealand are required to self-isolate for 14 days. Every person coming in has to fill out a comprehensive set of questions, and we'll put those up—a link to those on our website.

That is the back of the new arrival card, with quite a significant number of questions about possible exposure to COVID-19, any symptoms, whether they have been tested, and so on. That happens on arrival. They're disembarked in small groups to be processed, so that there's not a big crowd of people there. The health officials at the gate, or when they're disembarked, talk about their plans for self-isolation. If people are symptomatic, then they are assessed and their temperature taken, and they are quarantined and tested. At the moment, we have 135 people in quarantine. Those who don't have plans that satisfy the officials there for self-isolation are then put into managed accommodation, and we have 1,405 people in that managed isolation at the moment. If someone does have a good plan, then they are required to go into self-isolation according to that plan—to travel to their home, and to do that.

Just a word, then, on primary care: yesterday, the Minister announced funding for primary care, including both general practice and pharmacy in the community. And I just want to acknowledge the front-line role of our primary care practitioners, both in general practice, those who are working in CBACs, and of course our pharmacists as well. They are playing a key role in both assessing and identifying and testing people for COVID-19. So the announcement by the Minister yesterday was for $30 million, of which $15 million is going into general practice and $15 million into pharmacy.

So, just to give you a feel for what that means for general practices, a general practice with about 5,000 people registered would receive around $12,000 as an upfront payment; if it was a high-needs practice, that would be $22,000. In addition, practices are eligible for the wage subsidy scheme, and we are doing further urgent work on funding for primary care for general practice to ensure they are financially sustainable. We'll be providing advice to Ministers in coming days.

So, just again, to acknowledge the role of primary care: a significant role there. They are working at the front line while our hospitals prepare. At the moment, we have a small number of people who are, or have been, hospitalised; so most of that care is happening out in the community.

And, finally, I just want to finish with some information in today's WHO situation report update, which has got a very good summary of the current evidence around transmission of COVID-19, and just a few of the excerpts from that—and we will put a link to this on our website as well.

So, first of all, symptomatic transmission: so the data from the published epidemiological and virological studies provide evidence that COVID-19 is clearly primarily transmitted from symptomatic people to others who are in close contact, via respiratory droplets, by direct contact with each other, or by contact with contaminated objects and surfaces. It seems that people are most infectious early on in the infection. That may be before, or just as, they are developing symptoms, and for the first two or three days. The average time before people develop symptoms after they have come into contact with the virus is around five to six days.

There's been a lot of speculation and some studies published around pre-symptomatic transmission, and, as I say, the average time between being exposed to and developing symptoms is five to six days. During the period when people are pre-symptomatic, some infected people can be contagious. However, that transmission occurs through the same routes as it does if people are symptomatic—that is, through direct contact with people and droplet exposure, or those droplets then being passed on to other objects and people being infected through that route. So it may be that people are infectious for one to three days before they develop symptoms. And it says here—the WHO say—"It's important to recognise that pre-symptomatic transmission still requires the virus to be spread via infectious droplets or through touching contaminated surfaces."

And, finally, asymptomatic transmission: so an asymptomatic, laboratory-confirmed case is a person who is confirmed to have COVID-19 but who did not, or does not, develop any symptoms. There are very few reports of laboratory-confirmed cases of people who are

truly asymptomatic, and to date there are no documented cases of asymptomatic transmission. This does not exclude the possibility it may occur, and some asymptomatic cases have been reported as part of contact tracing in some countries. The important thing here is that, whatever the transmission, whether it's symptomatic, pre-symptomatic, or indeed—if possible—asymptomatic, the same precautions will protect people—that is, physical distancing, not going out if you are unwell and putting others at risk, cough and sneeze etiquette, and—very importantly—meticulous hand hygiene. Thank you very much; I'll hand over to Sarah.

Sarah Stuart-Black: Thank you. Today I thought it would be useful to explain how we're providing support to older New Zealanders. Since 23 March, about half a million New Zealanders aged over 70 years have been in self-isolation along with the rest of us. Many of these people will have the support from family, friends, and neighbours nearby, but some won't. Some older New Zealanders may not have access to the internet, may not be aware of the help that's available to them at this time.

From 30 March, check-in calls started as part of a response supported by the Ministry of Social Development regional commissioners. They're coordinating through their local networks to make these check-in calls. We also know that people from community organisations and volunteers from senior networks are also providing support. The calls are starting with a smaller group of older New Zealanders who may not be receiving information on where to get the help that they need. Many people contacted so far have reported that they appreciated the call, and that the large majority also reported that they already had all the support that they needed and were coping well.

Referrals for service are being made, and in some cases, where people have asked, follow-up calls are being scheduled. The network of calls to check in on people will widen to include older people with high needs. Also, an email has been sent to 324,000 seniors, assuring them that their payments would continue as usual, and ensuring they knew that their winter energy payment would be doubled for this year.

The SuperSeniors newsletter—a special COVID-19 edition—has also gone out to this group, full of information to support their health and wellbeing, point them to where they can get help and information, and to assure them that they're not in the situation alone. If concerns are raised, they are being referred to the local Civil Defence Emergency Management Group to provide assistance.

I'd like to thank all our network partners for each playing their part in helping us look after some of our most vulnerable citizens, and also encourage people to look out for their older neighbours living next door, to check in with them, make sure—by phone or text messages—to see if they're OK.

I just want to talk about volunteering. We've received many offers of community assistance from volunteer groups right across the country, and I'd like to thank you so much for stepping forward and being so willing to help. A workstream has been established to provide national coordination and information—it will tap into existing groups and their processes and networks. More information will be available soon, but in the meantime we just ask those who are willing to be able to stay at home and stay safe, and we'll come out with more information as soon as we can.

The last item I'd like to cover is around the national action plan issued from the National Crisis Management Centre. These are standard documents produced in emergency responses that describe how response objectives will be achieved—these are not secret documents, and they are distributed widely across agencies involved in the response. There shouldn't be anything in this document that should surprise people—we've been open about what we're trying to achieve with the national response.

The objectives and tasks in the action plan give effect to the COVID-19 alert level four. They set out what our overall mission is, what our objectives are, and the high-level approach and tasks that will be undertaken to achieve those objectives. Having an action plan ensures that everyone involved with response is on the same page and is clear about

what they need to do. The national action plan number two for the COVID-19 response also had attached to it the national action plan number one as a summary, and was sent out on Wednesday. It focused on the level four alert replacing that number one version of the national action plan, it outlined initial actions before the alert level was raised. The term "eliminate" in the document referred to the alert level four "eliminate". This is a COVID-19 suppression strategy that aims to ensure that the health system capacity is not exceeded, by preventing widespread outbreaks. The national action plan will be published on the COVID-19 website today.

And finally, as we head into our second weekend in lockdown, I can't reiterate enough the importance of staying home to save lives. We're all in this together. Do get outdoors for some fresh air and exercise, but stay local. Travel should be restricted to essential travel and for people to buy food or medical supplies. Thank you to everyone for everything you're doing to make sure that we're able to unite against COVID-19. Thank you.

Media: Can I ask about the Bluff cluster? The numbers there have gone up quite a lot in the last couple of days. What was that event that centred around it, and are you concerned by the rise in those numbers?

Bloomfield: The event was a wedding and, I mean, I think the numbers are going up, but what that represents is that all the close contacts have been identified, they've been self-isolated and been tested if they become symptomatic. So I think it's good that we are finding those cases because then we can take appropriate action.

Media: Dr Bloomfield, are hospital beds or temporary medical centres being built inside shipping containers?

Bloomfield: Not that I know of at the moment. With our hospitals having freed up capacity by stopping elective surgery, they have got a lot of space there, and I know that they are looking at all the options. Now, some of those may involve using shipping containers for some elements of what they need to do, but I don't know of any at the moment that are using shipping containers.

Media: How many of those would you look at using if you did, kind of, move into those types of makeshift hospital spaces or hospital beds? What would they look like?

Bloomfield: Well, it would depend on the location, remembering that the first choice is, of course, to use our existing hospital space, and many of our hospital buildings have space that is currently being used for offices that can be converted. For example, at the Hutt Valley hospital they've opened up what was the old ICU—had been used for office space for several years—to become a spillover for additional ICU capacity if needed, so we would use that. And, of course, we also have our private hospital facilities that we can call on. They would definitely be where we would go first.

Media: What are some of the other things that you're potentially looking at using to kind of create more space? Would you charter boats or anything like that—cruise ships? Is there anything like that that the Government—

Bloomfield: We're not looking at those other options at the moment. They would be further down the track if we needed to, but we do have plenty of space in our hospitals and, of course, with our private sector capacity as well.

Media: Sorry to do this—can I just confirm the numbers at the beginning? So you said there were 49 new cases and 20 new probable cases?

Bloomfield: Forty-nine new confirmed and 22 new probable.

Media: Twenty-two?

Bloomfield: Yes, correct. So a total of 71 new cases to report.

Media: The national action plan—does that include targets and will we be able to use those in order to make a determination of when we step back from level 4?

Stuart-Black: So I think that's a separate piece of work that's being developed is around how do we move between the different levels, and that's based on the public health advice. This is really saying, "What are the actions that need to be taken in order to give effect to where we are now in level 4?" And it's trying to make sure there's a real consistency with all of the agencies involved in the response effort. So it's acknowledging what the actions are now, rather than being future-focused about what might end up happening.

Media: Are you able to provide more detail on who's working on the other action plan, then, about transitioning from levels? Who is working on that, and when can we expect to see that?

Stuart-Black: I don't have a time frame for that, but it's being done as part of the all-of-Government leadership team for the response.

Media: Can you please clarify the buddy system for people living on their own? Some people are unsure whether they're allowed to form a small bubble with another person or another household, and, if they are allowed to, whether they have to sleep there, or if they can sleep in their own home.

Stuart-Black: I'll hand that to Ashley.

Bloomfield: So my understanding of the advice is that you can have a bubble that involves more than one house, but not more than two houses. I saw a story yesterday about someone who had arranged a bubble with two other single friends, but the application of it was actually they should just have a bubble with one other household, and I think that's the important principle.

Media: Dr Bloomfield, has the ministry had any concerns passed on to it about patients with suspected COVID being refused transport by ambulance services on the basis of them trying to protect their staff?

Bloomfield: I haven't had any reports of that, no. What I can say is I understand that our ambulance services, in line with international best practice, if someone requires—potentially requires—resuscitation and they are a confirmed COVID-19 case, then they wouldn't perform resuscitation, because that's an aerosol-generating procedure, and that's in line with what's happening globally.

Media: Do you know if ambulance services have been utilised much in terms of the COVID cases that are in hospital? Do you know how much contact ambulance services have had with COVID cases?

Bloomfield: I don't know, but I do know that our ambulance services have got access to protective equipment if they need to—the full suite of protective equipment—so they would be able to transport people safely.

Media: The college of GPs have called for an emergency cash injection from the Government, saying that some GPs are working for free and others are being laid off. Is this being considered at all by the Government?

Bloomfield: So there was the announcement that the Minister made yesterday of a cash injection, an upfront cash injection, and that is to assist with, first of all, the preparation and delivery of COVID-19 - specific activities but also the costs associated with transitioning to providing virtual consults, and there is further work under way about ensuring revenue streams to primary care, given that two of their significant revenue streams, patient co-payments and ACC payments, have dropped away quite a lot. So, yes, that work is actively happening with primary care leaders involved in it.

Media: The college is also asking for the deadline for priority groups such as over-65s to get the flu vaccine deadline extended until the end of April. Is this being considered?

Bloomfield: It's being considered. What we are focusing our flu vaccination campaign on, at least into the middle of April, is getting those high-needs priority groups,

the ones that are publicly funded: over 65s, people with pre-existing conditions, pregnant women, and children who have got pre-existing respiratory problems.

Media: Where are things at with repurposing ventilators?

Bloomfield: At the moment we're not having to repurpose ventilators. We have 533 available in the public system. We are also just working out arrangements with the private sector to be able to access theirs, and there will be an announcement about those shortly, and we are finalising some orders—actually, we've got orders finalised; we're just finalising the dates for arrival of additional new ventilators from overseas, and there'll be another announcement about that when the delivery dates are confirmed.

Media: If health workers are feeling unsafe, should they be allowed to use their own PPE gear?

Bloomfield: Well, I would hope that they don't have to use their own PPE gear. The guidance around when they do and don't need to use PPE is very clear. What we have done, of course, this week is made sure that there is enough PPE available in our hospitals or on the front line for people to use it if they feel they need particularly a mask to feel safe in the situation they're in.

Media: Can they use as much PPE as they like, over and above the guidelines, if they do feel at risk?

Bloomfield: Well, PPE—we've got very good stocks and very good supplies coming, but nothing is an infinite resource, so it needs to be used appropriately—that is, safely—and it also needs to be used wisely, just like any of our healthcare resources.

Media: But if they're sourcing it themselves then it doesn't come out of the national—

Bloomfield: If they're sourcing it themselves then that's up to them, but, again, what I would encourage anyone using PPE is to use it properly, because it is not—it needs to be done in conjunction with those other health and safety measures, particularly hand washing.

Media: In your mind, could excessive use of PPE cause anxiety or panic to other people?

Bloomfield: I think it just needs to be used appropriately. I'll just leave it at that.

Media: A woman who was symptomatic, and she'd recently travelled to Australia, she was refused a test both from her GP and from a testing centre. Should that be happening?

Bloomfield: Well, I can't comment on the experience of individuals, but I do have confidence in our clinicians at the front line. They're the ones making the assessment and they would know whether a test was indicated or not. You'll be aware, of course, that the testing criteria have been widened this week, and I think we've seen the result of that. We did see 3,446 tests undertaken yesterday—quite a bit higher than the previous daily high point—so that's good. We want to be testing and finding these cases. But I don't want to second-guess the judgment of clinicians who are seeing people.

Media: GPs are still telling us, though, that they aren't getting enough of these tests. Is it flowing through, this widened testing criteria?

Bloomfield: I think the criteria are flowing through, in terms of when people are able to test or order a test. One of the areas I know there has been some isolated issues around is access to the swabs, and so we're working on making sure that those are distributed. We have plenty of swabs, but we just want to make sure that those are distributed out to where they're needed. There might be the occasional disruption in supply, but we can address that quickly. We're working on that.

Media: Just on the testing, why is it that we're still now more than 1,000 short in reaching the daily capacity—is it because of these issues, or is it because we're not seeing enough people through the door with symptoms that need testing?

Bloomfield: I'd say it's the other way around; I would say it's because we have done an excellent job in ensuring we have sufficient capacity and we keep increasing that. So our capacity now is, really, amongst the leading countries in the world in terms of our per capita capacity, and we want to make sure that capacity remains ahead of the testing we need for diagnosis, because we want to be able to use some of it for surveillance, as well, to help us inform decisions around movement between the different alert levels. So I would say the speed with which we have been able to increase our testing capacity is reflected in that gap between actual testing and the capacity.

Media: But surely we should be testing as much as possible, and we've never once met the quota, even when the capacity wasn't ramping up as significantly.

Bloomfield: So our testing has continued to increase, remembering that two weeks ago we didn't need to test as much because there wasn't as much infection in the country and there wasn't as many close contacts to test. So many of those people being tested now will be close contacts who might be developing symptoms—that's why we've seen these clusters and quite a few cases being diagnosed. I think, again, just to reiterate, we have very good testing capacity, it's spread around the country, it's not reliant on a single platform, and our testing criteria are now broad—in fact, they are as broad as pretty much any other country, and so we want to keep finding those cases and ensure we have capacity to do surveillance testing as well.

Stuart-Black: Last question. [*Interruption*]

Bloomfield: Sorry, I'll take this question, and then the one at the back.

Media: Have you received a recommendation letter from the Māori pandemic group regarding ethnicity—collecting data on ethnicity—specifically when it comes to testing COVID-19?

Bloomfield: Yes, I have. I got that letter yesterday, I read it this morning, and it's got some great recommendations about the importance of ensuring we have accurate ethnicity data. We know from previous pandemics, and situations like this, that Māori—and also other populations, like Pacific—tend to be at higher risk of poor outcomes, so we want to have good ethnicity data and we'll be implementing those suggestions that they have made. Final question down the back.

Media: Testing from Iceland shows that 50 percent of people are asymptomatic when they have the virus. If we're only testing for people who have symptoms here, how confident are you that our data is accurate?

Bloomfield: Well, I think the more testing we do, the better our picture will be of the extent of infection, and that would also be the point of doing some more population-wide testing as part of our surveillance, to determine what degree of asymptomatic infection we might have. But, just to go back to that WHO summary, actually, the extent of truly asymptomatic infection seems to be very low, from all the evidence around the world. And, also, the point I made there, that even if the infection is asymptomatic, those precautions—those basic precautions—will protect people from becoming infected.

Media: Should someone be allowed to drive two kilometres to go to a biking trail?

Bloomfield: I think anyone who is undertaking physical activity—which is important for both mental and physical wellbeing, and you will have heard me say here before, I think cycling in particular is a great activity—anyone should do so safely, and locally. Final question.

Media: If there's an inherent risk, though—and mountain biking is inherently risky and you could end up pulling out search and rescue volunteers from lockdown—should mountain biking be allowed?

Bloomfield: Look, any physical activity should be done safely and locally—I can reiterate that point. Thank you very much, we'll see you tomorrow.

conclusion of press conference