31 March 2020

ALL OF GOVERNMENT PRESS CONFERENCE: MONDAY, 31 MARCH 2020

Dr Ashley Bloomfield: Kia ora koutou katoa. Welcome to this afternoon's briefing. And the reason why the briefing has been delayed by half an hour today is that the Minister of Health and myself were appearing before the first day of the sitting of the new COVID response committee that's chaired by the Leader of the Opposition, Mr Simon Bridges, and—Honourable Simon Bridges—so, hence we just put out the media conference by half an hour. But thank you for being here.

So, today, there are 48 new confirmed cases of COVID-19, and 10 probable new cases. So, in other words, 58 more cases than yesterday. There are no additional deaths from COVID-19 to report, and we can now confirm that 74 people have recovered from COVID-19 infection. This brings the combined total of confirmed and probable cases in New Zealand to 647. Now, whilst this is a drop in the number over the last day or two, I have no sense that this is a drop overall, and our expectation is that the number of cases will continue to increase. The number of cases may reflect that there were lower numbers of tests done on Sunday, in particular, and that's what we're seeing come through. Our full expectation is that the number of cases will continue to increase over the coming seven to 10 days; then our hope is they would start to decline, particularly if people keep doing as asked of them and maintaining social distancing and isolation.

There are 14 people in hospital currently with COVID-19, in a range of hospitals across the country, the details of which will be on our website. I can tell you that two people are in intensive care, both are stable.

Our laboratories across the country continue to process tests, and the average daily number of tests over the last seven days is 1,777. We have more testing capacity coming on board later this week, with additional labs taking up testing as well.

We are still seeing that strong link in our positive cases to overseas travel, 53 percent, as well as them being confirmed—or close contacts of confirmed cases, 29 percent of them, and around 1 to 2 percent at the moment are community transmission. We will expect the latter proportion to increase.

We're also continuing to actively investigate and contact trace a number of clusters of COVID-19 infection. We are reporting those on our website, and the numbers—both the numbers and the locations of those clusters—and updating daily the numbers of confirmed cases.

There has been a lot of ongoing interest in personal protective equipment, and just an update on that: it's very important, of course, that we keep our front-line health workers safe. And, on our website, there has been—and the COVID-19 website—very clear advice around the situations in which healthcare workers, front-line healthcare workers, need to wear PPE in different contexts, depending on the people they are caring for.

However, I am also conscious that our front-line heath workers not only need to be safe, they need to feel safe, and I know that many of them are particularly concerned about elements of that advice. I think it's very good advice, it's from infectious diseases specialists, and it's designed to ensure that they know what PPE to wear in different situations. But I am conscious that many of our front-line healthcare workers are concerned about not having access to masks when they feel they need them to feel safe.

So, we've—we're undertaking a process at the moment, of leasing a large number of masks from our national stocks out to our district health boards, and they will be distributing, in their regions, masks to front-line health workers in a range of organisations, including our home and community support workers and disability support workers, some NGO workers where they have face-to-face contact, pharmacies, and other providers. The

purpose of this is not to contradict what is in the guidelines, because I think the advice in the guidelines is very good and it's based on the best evidence. However, we also want our front-line health workers to feel they can access PPE for when they want—they need—to use it.

And this, of course, is only part of keeping them safe; it's also important they know how to use PPE. Even putting on a mask needs to be done properly; the use of gloves needs to be done properly to help prevent the spread of infection. And, of course, the mainstays of keeping them safe are: not going to work if they are unwell, and keeping their people they are caring for safe in that regard; meticulous hand washing; distancing where appropriate, but often not possible in a clinical context. And so the release of the masks is designed to complement and support these measures and support our health workers in the front line.

Just, finally, a comment on modelling. Many of you will be aware that we've today published a series of modelling reports that the ministry commissioned over about a month, the last of which was on 24 March. And these were updated, as we went through the last month or so, to take into account newly emerging evidence and experience in other countries. However, they paint a sobering picture of what the impact of COVID-19 would be in Aotearoa New Zealand if we were not taking a very decisive and strict approach to our response—that is the implementation of the alert level 4 measures. So without the actions currently being taken, the uncontrolled spread of COVID-19 would clearly exact a high price on New Zealand in terms of its impact on our healthcare system, on our healthcare workers, and, of course, in a large number of deaths. So they do present—-each of the models does present this stark choice between acting decisively and going early and going hard, and the counterfactual, which in, I think, anyone's terms was unacceptable.

We need to take this virus seriously, and part of taking it seriously is now ensuring that we get the best possible outcome from the alert level 4 measures we have in place. That, of course, requires—and I can't say it enough—everybody to play their part and observe the self-isolation rules that are in place, and to avoid social contact. That is how we will collectively break the chain of transmission. As I say, those modelling reports are on the Ministry of Health's website. Sarah, I'll hand over to you.

Sarah Stuart-Black: Thank you. Firstly, I'd like to thank everyone for all you're doing to help stop the spread of COVID-19. The small things we do as individuals make a real difference. I saw this in action first hand on one of the few times I've been out of my work-home bubble. This Saturday, at my local supermarket, people were doing something most of us have never had to do in our lifetimes: queueing quietly outside the shop, maintaining a safe physical distance, and checking in with the person behind. I also visited a chemist yesterday and the staff said that people are being respectful and thoughtful of others, including only taking one product to leave enough for others—and that is fantastic. It confirmed for me that Kiwis are really uniting against COVID-19.

To help ensure you're supported by agencies and services in your local community, I want to outline how we're working with our local government partners. Local Government New Zealand and the New Zealand Society of Local Government Managers have teamed up with the Department of Internal Affairs and the National Emergency Management Agency and other relevant Government agencies to establish a COVID-19 local government response unit. In recent days, the Government has broadened the eligibility criteria for the regional civil defence emergency management groups to provide support to people in need. Previously, this assistance was limited to people who were displaced following an emergency.

COVID-19 presents the opposite challenge, with people confined to their homes. These measures will help people to access essentials such as food and medication, and will particularly assist the disabled, at-risk groups, and people without access to their own transport. These services are intended for those facing hardship, and are offered in addition to a range of other support measures provided by other agencies, but particularly the Ministry of Social Development. So from today, the regional civil defence emergency management groups up and down the country will be operating local helplines.

Furthermore, we have invited those same regional CDEM groups to proactively approach their local foodbanks to replenish their stocks. The Government will reimburse the groups in full for any goods or services provided under these arrangements. We'd like to express our gratitude to those CDEM groups for standing up these arrangements so quickly to make this happen, and particularly the work of mayors, regional council chairs, senior local government leaders and controllers. This is about local and central government coming together to literally deliver support to the doorstep of those who need it the most.

On behalf of our local authority partners, there's one thing that I, that they, and we, need people to do—or, rather, stop doing. Slightly more practical: wet wipes. They are a major problem for councils' waste-water treatment plants and sewerage systems. As people rightly become more vigilant about hygiene, the use of wet wipes has increased markedly. Unfortunately, disposing of wet wipes down the toilet leads to extra blockages in the sewer network, and this includes flushable wet wipes. So the bottom line is, if you'll beg my forgiveness: please, always put wet wipes in the rubbish and not in the toilet.

On some other matters: repatriation of Kiwis. We continue to support those who have arrived home who do not have an isolation plan. We're ensuring those people are safely housed and fed in managed accommodation. However, more are arriving with a good isolation plan in place, so fewer need to be accommodated unless they have symptoms. I'm also pleased to say that 54 people who have been in temporary accommodation are being flown to Wellington and then on to Christchurch to continue self-isolation in their own homes. This process is being carefully managed to keep these people in their bubbles and away from others.

In terms of visitors from overseas, we're working on how to help temporary visitors wanting to leave New Zealand and get back to their home countries, but this is complex work and more difficult because of the reduction of commercial flights out of New Zealand. In the meantime, it's important for these people visiting our country to stay in self-isolation in their current location and keep in touch with their relevant embassy or consulate.

A couple of issues we're observing in our cities: people are congregating in groups in outdoor places such as parks and playgrounds, beaches, and urban areas as well. Please don't. If you're outdoors, practise the physical distancing; don't gather where others are. Please don't take your children to playgrounds and parks and schools—there are too many objects or surfaces potentially with the virus on them. And, likewise, stay off any furniture or equipment in public places. And, unfortunately, the Kiwi tradition of passing something over the fence to your neighbour is not advised either.

Please keep being kind. We're all in this together. People who have or suspect they have COVID-19 need to be treated with compassion and support. No one catches this virus on purpose. After all, we are truly in this together. So let's stay united in the fight against COVID-19. Thank you.

Media: Can we ask you about GPs? There is talk today that they're struggling. Is there any plan to help out some of those GP services?

Dr Ashley Bloomfield: Yes there is. And my team were in touch with general practice leaders over the weekend, and I spoke with a couple of them, as well. So there is a very active piece of work to both quantify where practices are struggling financially and to help provide support. And so that work is well under way.

Media: When can they expect some information and some certainty around that?

Dr Ashley Bloomfield: During this week. There was some certainty last week with that first announcement, and the first payment out to general practices was provided. That was an upfront payment to help them with their response to COVID-19, but there is further work on sustainability that will be landing this week.

Media: On the modelling, Dr Bloomfield: how seriously should people take those worst-case scenarios?

Dr Ashley Bloomfield: Well, they should take them very seriously, in the sense that that is what would happen if we weren't being proactive and acting. And you'll see from the series of reports that as we've implemented additional measures, we've been able to remodel and reforecast what the impact of this disease might be on our health system and on the number of deaths and on our population. So what we are now, of course, is in a situation where we think we cannot just turn around but get back down to—our aim is to eliminate it again. It will be very difficult to get back to zero, and now our work is on to see when that might happen—so some scenarios around that. And, of course—and the WHO is doing some advice on this at the moment—is what might be the triggers for relaxing some of the current measures we've got in place.

Media: And what's the longest you're willing to keep us in lockdown to prevent those worst-case scenarios?

Dr Ashley Bloomfield: Well, it will be up to the Government to make that decision.

Media: Can you just clear up, is this an eradication plan we have at the moment. Nick Wilson told Stuff this morning there was a lack of strategic clarity from the Government on whether we were trying to just supress or eradicate the virus.

Dr Ashley Bloomfield: Well, we've been clear all along that one of the reasons we moved quickly into alert level 4 is our aim is to break the chain of transmission. So, yes, ideally we want to break it, and, if we stay in this position and are rigorous about enforcing the physical distancing, then the aim would be to eliminate it.

Media: Just a supplementary on that question from Claire: Professor Wilson also said that we need to be testing at several times the current rate, including random testing of anyone in communities with those respiratory symptoms. What do you make of that?

Dr Ashley Bloomfield: So two comments. First of all, our testing is increasing all the time, as is our capacity. So we've got more capacity than we are doing testing, so we do want to increase testing, because we want to find all these cases. Secondly, our technical advisory group actually just met this morning, and we are revising the case definition. So I can't say anything more about that because I haven't been briefed, but we're expecting that case definition to widen to ensure that there is not necessarily a travel history required or that history of exposure to a confirmed or probable case. I should say that since 14 March there has been that ability for clinicians to apply discretion anyway even if there wasn't that contact history.

Media: What prompted the case definition widening? What was the specific reason for that?

Dr Ashley Bloomfield: Well, actually, our technical advisory group meets regularly, and it constantly is reviewing the case definition, but specifically it's a response to the increase in the number of cases and evidence of community transmission.

Media: With ventilators, how many do we have at the moment, how many do we need, and are we working on getting any more? Is that even possible in a pandemic?

Dr Ashley Bloomfield: So I can put a number on the number we have at the moment: that's 533. There are also quite a number in the private sector that are available to be used if necessary, and we have already ordered additional ones from overseas and will provide that information on our website and just show the expectation around the additional ventilators. Of course, the corollary of that is ensuring we have enough staff trained, and so that training is happening now in our district health boards.

Media: How many more do we need to be safe and to be sure?

Dr Ashley Bloomfield: Well, it depends on what happens in terms of our scenarios, but what we are doing, of course, is gearing up and continuing to get more capacity so that we have as much available as is needed or as is possible by the time we do get an increase in cases in our health system.

Media: Regarding the nurse in Queenstown who's tested positive, how concerned are you that this is a likely case of community transmission?

Dr Ashley Bloomfield: Well, I think that's always a concern. In any case, actually, we want to be really clear about and investigate thoroughly to find out where they got the case from. And, actually, in this situation, the other staff close contacts have been tested, and we're awaiting the results of those tests.

Media: Just to follow on that, if I can: what does it mean for the emergency health cases in Queenstown Lakes District? Will all patients need to be flown to Invercargill or Dunedin?

Dr Ashley Bloomfield: At the moment, the emergency department is still open, so there's an ability to respond to acute needs. It's just the inpatient care, which is usually a very small number of people anyway. That will either go to Dunstan or to Invercargill.

Media: Of the ones in hospital, how many of them were put into hospital after being diagnosed, or were any of them already in hospital and it was later diagnosed as COVID?

Dr Ashley Bloomfield: Sorry, I don't have that information. I'll see if we can get that for our website, but that's quite a specific question I don't have the answer to.

Media: [*Inaudible*] West Coast case, I thought—

Dr Ashley Bloomfield: Yes, in the West Coast case, it was [*Inaudible*].

Media: All this disease modelling that was released today, it also talks about it's the over-60s where you're expecting 85-90 percent of the deaths to occur with coronavirus—around those worst-case scenarios. So why was it the original advice for over-70s to stay at home and not over-60s when all the modelling talks about it being the over-60s that are the most vulnerable?

Dr Ashley Bloomfield: Well, it depends where you draw the line. The increase in age increases the risk, so it's over-60s, yes, and, in fact, we've got everyone now in self-isolation. And what we did do very early on, even before we got to alert level 2, was we advised aged residential care settings to stop visitors and to ensure that staff knew that if they were symptomatic not to come to work. So we have been taking, I think, quite a proactive approach around our older population, because, as you say, that is the group that is the most impacted by serious illness and death.

Media: Do you believe that the actual number of cases of community transmission is much higher than what has been confirmed? Sir David Skegg said, this morning, that we really have no idea of the extent of community spread. Do you share this view?

Dr Ashley Bloomfield: Well, we have some idea, so I disagree with him in that sense. We know where our cases of community transmission are, and we know we have these clusters, which are being investigated to see what the source of infection is there. So we have some idea. The more testing we do, the more we will get a picture of the level of community transmission, and what we want to do is build up that picture in individual regions, as well, so that we know just where there might be community transmission happening. It may be happening in some regions but not others.

Media: Dr Bloomfield, the Government says it's looking into the possibility of an outbreak in the Māori and Pasifika community. Are you particularly concerned about that? What does that look like?

Dr Ashley Bloomfield: Well, I'm very concerned about those two communities and other vulnerable populations. People with disabilities are another example. We know from the 1918 Spanish flu pandemic that Māori were hit particularly hard, and so we've got particular work happening to ensure that Māori leaders in those communities, both Māori and Pacific, are involved in planning and ensuring that the messages get out appropriately, that those communities know what is required of them to help prevent transmission, and, of course, we'd be very thoughtful about making sure that if there were cases amongst

communities where there were high proportions of Māori and Pacific that we were being very, very active with our contact tracing and follow-up.

Media: Are there any new cases involving Air New Zealand staff?

Dr Ashley Bloomfield: Not that I've been told of, no.

Media: Why are Air New Zealand staff not being put into mandatory self-isolation when they get home from trips?

Dr Ashley Bloomfield: So the flight crew, and indeed crew coming in on ships, are not required to self-isolate if they have taken appropriate precautions during the trip. It's different on ships, but flight crew are able to take precautions, and we've done this right through from when we actually evacuated the New Zealanders out of Wuhan. Ensuring that they're taking appropriate precautions means they don't have to go into self-isolation.

Media: Dr Bloomfield, given your initial remarks that on Sunday the testing dropped off, is there a particular reason for that? Was it a capacity issue or—

Dr Ashley Bloomfield: It wasn't a capacity issue. There were two reasons, we think. One is that there were less people going to the community-based assessment centres for swabbing. This is a typical pattern in our healthcare system. Generally, there's lower level of care provided on a Sunday and then Monday tends to be another big day. I think the second thing is just the availability of couriers and so on on Sunday, but we're going to look at that, because we do want to make sure that people who need tests are able to get them any day of the week.

Media: And are you able to say how many asymptomatic cases have returned positive results?

Dr Ashley Bloomfield: No, I don't have that data, sorry.

Media: In Germany, they have a system where when someone has recovered they get a certificate. Is that something that we would consider doing here?

Dr Ashley Bloomfield: Well, we'd certainly consider it, and if the purpose is to help assure others that the person has got over their infection—they've both got over their symptoms and then been self-isolated for a period of time—we could do that. But I'd have to look into what the benefits might be of doing that.

Media: You previously said that one of the, sort of, big focuses is making sure that COVID-19 is not transmitted within health institutions like hospitals, but we've seen one case of someone—at least one case of someone admitted with COVID-19 but treated as influenza, and then this nurse in Queenstown who's now contracted the virus. Are you confident that it isn't already transmitting in hospitals?

Dr Ashley Bloomfield: Well, it's impossible for me to say I'm 100 percent confident, but what I can say is that the learning from the case on the West Coast was that anyone coming to a hospital—for example, through an emergency department—with a respiratory infection should be treated and managed with appropriate PPE as if they were COVID-19 until that's ruled out.

Media: Dr Bloomfield, how many positive cases are healthcare workers and/or essential workers?

Dr Ashley Bloomfield: I don't have that exact figure, but let's see if we can find that number and include that on our information on the website for the cases where we know enough.

Media: Dr Bloomfield, what are the ages of the confirmed cases in hospital? And are either of those people in ICU under the age of 50?

Dr Ashley Bloomfield: I don't have any demographic information about the people in ICU or, indeed, the people in hospital, so I can't provide that to you.

Media: Ms Stuart-Black, there have been calls more recently to enforce a curfew after dark or potentially to ban over-60s, over-70s from actually leaving the house. Are we at the point where we need to consider those sorts of more radical, more restrictions to enforce compliance?

Sarah Stuart-Black: I think what we're seeing is generally people are adhering to the advice and they are staying in isolation. The cases we're seeing where people are out congregating are still relatively few numbers, and I'm just really appealing to those people to please just stay with us on this and help be part of the solution for trying to prevent deaths. It's an active point of consideration for Police, alongside Health, in terms of having an evidence basis from a public health perspective about informing decisions if we needed to do things differently, but we're not looking at that yet. Would that be fair to say?

Dr Ashley Bloomfield: No, I haven't had any discussions about that yet.

Media: Dr Bloomfield, a couple of questions on testing. We're still hearing of people who were referred by their GPs but then being refused tests when they get to the testing centres. Why is that happening? And what assurances can you give those people that that

Dr Ashley Bloomfield: Yeah, so I learnt about some of these and was questioned on some of them this morning in the committee, so we'll look into that. But I do think that, you know, the clinical assessment that's made by the people at the community-based assessment centre, that's all they're doing is seeing people coming through and they are assessing them, and they've got a really clear set of criteria whereby they assess them. I think, if the criteria broaden—and we'll see what happens with the revision of the case definition—then this will be less of an issue.

Media: Are you able to say how many people have been tested at the Matamata site since it was set up yesterday?

Dr Ashley Bloomfield: No, but we'll see if we can get that information and provide it.

Media: You just said you're going to change the definition. Can you tell us a bit about that, or when would you look to do that and what would make that happen?

Dr Ashley Bloomfield: Yeah, so the technical advisory group did meet this morning, and I specifically asked them to look at the definition given that we now have evidence of some community transmission. The key thing I wanted them to look at is whether we decouple the symptoms that form part of the definition from the requirement to have a travel history or to have been a close contact of a confirmed or probable case, notwithstanding there was already that ability for them to test someone even if they didn't fulfil those criteria. So that would be a key change, I'm just waiting to get that advice and I'm expecting that later today.

Media: [*Inaudible*] also considering other forms of testing? Overseas, they're talking of doing finger-prick tests and things like that. Are the Government taking any alternative testing into consideration?

Dr Ashley Bloomfield: We're looking at all the different testing modes that are being looked at and developed overseas. And, in fact, we've got a particular stream of work on looking at both the current testing, which is the PCR-type testing to diagnose—which identifies the virus to diagnose the illness. There's also some work happening internationally around antibody testing to see if people have had the infection post-hoc. The latter is much less well-developed. There are also different ways of testing, like rapid testing and so on. We're looking at all of those actively.

Media: Given we're testing about 1,800, on average, and we've got the capacity to test at a thousand, and you're hearing from people like Sir David Skegg, who says that the testing's misleading, we need to be doing far more; from Professor Nick Wilson, who's also saying we need to do far more, why can't we test at capacity? Why not have loosened the criteria sooner, as well?

Dr Ashley Bloomfield: So, I think the important point here is capacity is not a constraint on our testing, and so what we do want to do—as you've said, and as I think Professors Wilson and Skegg agree with—is we want to find all these cases, because then we can take the appropriate action, and that's specifically why I've asked the technical advisory group to look at that definition, to make sure that it is not constraining testing the right people and finding positive cases. Two more questions, if that's all right.

Media: Just with the St Patrick's Day event—which was, obviously, March 17—it was 10 days before the COVID-19 case was picked up there. How significant could that cluster be, and how many cases are you expecting to see out of it?

Dr Ashley Bloomfield: Well, I can't say how many cases we're expecting, but, yes, that means there was quite a period of time for the index case, the first case, to have a number of close contacts. So hence, there is a big effort going in to trace and isolate all those close contacts, and to test those who need testing. It's very important to be extremely thorough in these sorts of situations. One advantage is that it's localised, different from, for example, the Hereford cattle conference down in Queenstown where people dispersed around the country—it's much more difficult to contact trace and isolate people.

Media: We've had community transmission for more than a week now. Why are we only looking at revising the case definition today?

Dr Ashley Bloomfield: So we still have very low levels of what we think is community transmission, based on the testing that's being done, We're revising the definition when we think it was appropriate. And also we wanted to make sure that professionals out there, our GPs and those working in CBACs know, and they have been, since 14 March, able to exercise that clear, clinical discretion. And my sense is we've done over 21,000 tests, it's clear there has been a lot of testing who haven't necessarily fulfilled the epidemiological criteria but the clinician felt that it was important to test them.

Media: Can I just ask, in regards to Māori and Pasifika, you've talked about the over-70s being particularly vulnerable, is there specific information or advice going to those communities, given life expectancy, given overwhelming negative statistics across a lot of health areas, is there really sort of specific detailed advice going to those communities around this?

Dr Ashley Bloomfield: Yes there is, and there's quite a large effort going in around both those communities. We've got several advisory groups involved—both health professionals who are providing that advice, but also linkages with key community leaders, iwi leaders for Māori, and so on, so yes. And there will be—or there is already—quite a lot of information on our website about the initiatives that are happening there, and I can say that that's a big focus for our work. Look, thank you very much—

Sarah Stuart-Black: If I can just say, Jo, it's also worth noting that we're embedding iwi liaison into the regional emergency coordination centres, so that we're making sure that alignment with iwi partners is tight between health but also emergency management outreach into networks right across the community.

Dr Ashley Bloomfield: Thanks very much.

Media: So on that, then, have you got Whānau Ora specifically working within that, as well, because presumably they will be delivering using the money that was announced last week to deliver to these communities, won't they?

Sarah Stuart-Black: Yes, so this work is all joined up with the general approach to welfare services.

Dr Ashley Bloomfield: Thank you very much, and we'll see you tomorrow.

conclusion of press conference