Australasian College for Emergency Medicine | The Royal New Zealand College of General Practitioners Te Whare Tohu Rata o Aotearoa | RNZCUC Royal New Zealand College of Urgent Care

JOINT STATEMENT

Resurgence of COVID-19 in New Zealand – Lessons learned

18 August 2020

The Australasian College for Emergency Medicine (ACEM), The Royal New Zealand College of General Practitioners (RNZCGP) and Royal New Zealand College of Urgent Care (RNZCUC) welcome the Ministry of Health and Government's swift action following confirmation of New Zealand's second wave of positive cases of COVID-19 community transmission on 11 August 2020. Since the onset of the COVID-19 pandemic, there have been numerous and complex changes to processes in our healthcare system. As peak professional bodies representing frontline doctors in the community, we wish to reiterate international best practices and lessons learned from our first wave, as well as from countries experiencing a resurgence of COVID-19 across the world. **These include:**

1. Protecting vulnerable populations

It is unacceptable to allow worse outcomes for New Zealand's already-vulnerable populations, particularly for the Māori and Pasifika peoples, elderly, those with comorbidities known to worsen outcomes in COVID-19 infection such as diabetes, obesity, hypertension and cardiovascular disease, and those with mental health issues.

a. Māori and Pasifika peoples

Inequities are exaggerated during pandemics, and it is the Government's responsibility to do as much as possible to mitigate these. Pandemics have also exerted enormous tolls on indigenous peoples throughout history, such as in Australia[1], Canada, the United States and the Pacific[2]. In New Zealand,

[1] Flint, S. M., Davis, J. S., Su, J., Oliver-Landry, E. P., Rogers, B. A., Goldstein, A., Thomas, J. H., Parameswaran, U., Bigham, C., Freeman, K., Goldrick, P., Tong, Y. C. 2010. Disproportionate impact of pandemic (H1N1) 2009 influenza on Indigenous people in the Top End of Australia's Northern Territory. The Medical Journal of Australia, volume 192, issue 1-: Pages 617-622. Doi: https://doi.org/10.5694/j.1326-5377.2010.tb03654.x (Available at: https://www.mja.com.au/system/files/issues/192_10_170510/fli10103_fm.pdf)

[2] La Ruche, G., Tarantola, A., Barboza, P., Vaillant, L., Gueguen, J., Gastellu-Etchegorry, M (for the epidemic intelligence team at InVS). 2009. The 2009 pandemic H1N1 influenza and indigenous populations of the Americas and the Pacific. *Euro Surveill,* volume 14, issue 42:pii=19366. https://doi.org/10.2807/ese.14.42.19366-en (Available at:

evidence from previous pandemics consistently shows higher mortality rates for Māori compared to non-Māori. For example:

- 1918 Influenza pandemic: Māori mortality rate was seven times more than the rate of the European settler population.
- 1957 Influenza epidemic: Māori mortality rate was six times more than the European rate.
- 2009 H1N1 Swine Flu pandemic: Māori mortality rate was almost three times higher than the European rate[3].

New Zealand's COVID-19 pandemic response must include equity for Māori and must honour the principles of Te Tiriti o Waitangi. Similarly, it should be focussed on culturally safe and appropriate care for Pasifika people in New Zealand. Without an equity-centred pandemic response, Māori and Pasifika people will experience multiple negative outcomes from this, which is simply not acceptable[4]. Similarly, healthcare workers need to be their patients' advocates for excellent healthcare, and ensure they do not suffer racial, ethnic or cultural discrimination during their care.

b. Older people and residential aged care facilities (RACFs)

The worldwide impact of this pandemic on the elderly has been disheartening. For instance, more than 40% of United States COVID-19 deaths are linked to nursing homes.[5] Effective protection of the elderly and the RACF-populations is essential. This will minimise the effect of the pandemic in New Zealand. Our morbidity and mortality rates will be low, and our healthcare system will be spared the overload of intensive care (ICU), acute wards and emergency departments (EDs) seen overseas.

We applaud Government advice for rest homes across New Zealand to go into full lockdown, after the latest resurgence of positive COVID-19 cases in Auckland[6]. Overall, we would recommend strict protocols for the management of RACFs that include regular testing of staff and residents, and strict visitation rules for family members, and not allowing healthcare or allied workforce to work at multiple sites. There needs to be a clear strategy to deal with the transfer of unwell elderly patients from RACFs to hospital and back safely to their residences as their healthcare needs determine, an issue that is causing problems in Melbourne currently.

In line with international practice and age group mortality data, we also recommend the definition of the at-risk elderly population age be amended to include all people over the age of 60 years. This also aligns with the World Health Organisation's definition thereof[7].

c. Mental health

Since the onset of this pandemic, we have welcomed the additional Government support in addressing the growing mental health crisis, including its mental support helpline 1737. It is vitally important the measures introduced are long-term, and sustainable, resulting in lasting improvements to the care provided to vulnerable mental health patients.

Presentations to EDs, general practices and urgent care facilities of people in mental health crises are also increasing in relative and absolute terms. Mental health crises often occur out of office hours, requiring services to be available at all times. In addition to telehealth and more appropriate community and home-based services provided, the Government must ensure that services providing out of hours care are properly resourced to cope with existing and future demand. This must also address the dangerously long waits faced by people in need of emergency mental healthcare[8].

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https://www.eurosurveillance.org/docserver/fulltext/eurosurveillance/14/42/art19366-en.pdf?expires=1597370897&id=id&accname=guest&checksum=C97AC2C174D2AA2D90C7BD9B89B4B4DE)

[3] https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/COVID-19/Resources/Clinical-Guidelines/Indigenous-Community-Recommendations

[4] https://www.rnz.co.nz/news/in-depth/414499/covid-19-virus-and-recession-a-devastating-combination-for-maori-and-pasifika

[5] https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html?action=click&module=Spotlight&pgtype=Homepage

[6] https://www.tvnz.co.nz/one-news/new-zealand/rest-homes-across-new-zealand-going-into-level-4-lockdown-three-days

[7] https://www.who.int/westernpacific/emergencies/covid-19/information/high-risk-groups

[8] ACEM. 2019. Communique: Mental Health in Aotearoa New Zealand Emergency Department Summit. Melboure. (Available at: https://acem.org.au/News/May-2019/Mental-Health-in-the-Emergency-Department-Summit-C)

2. Mass masking

We welcome new Government advice on the public use of face coverings and would like to see it continue to give a strong clear message promoting mass masking, supported with legislation, if required.

International research[9] and experience, including recent Australian data[10], indicate that compulsory face coverings in areas where there is community transmission reduce COVID-19 transmission significantly.

We therefore recommend that the new mask advice be widely applied throughout the country, and not just in Auckland, to reduce spread in the event of undetected community transmission. This will help keep the transmission rate below one, at which point the pandemic will abate.

We also welcome the introduction of mandatory face masks on flights[11].

3. Healthcare worker infections

The increasing rates of COVID-19 infections among healthcare workers across the world are concerning. We need to be vigilant, and stringent infection controls need to be in place. All healthcare workers have a right to be safe at work, and this needs to be at the very top of the priority list for Government, healthcare systems, district health boards (DHBs), hospitals, primary health organisations (PHOs) and practices. They need the best protection available, according to international best practices, including nationally consistent PPE guidelines and reliable access to masks and face shields. Without PPE, there cannot be wellbeing. We would not want the same scenario here, as in Victoria, Australia, where more than 1,100 healthcare workers have now been infected with COVID-19, and accounts for up to 11% of all of its active cases[12][13], and numbers continue to rise. To our colleagues, we wish to reiterate: Be careful, wash your hands, wear a mask, continue to practice physical distancing, and use appropriate PPE[14]. It must also be noted that a significant portion of the healthcare worker infections in Victoria occurred outside of direct patient contact, so care also needs to be taken in non-clinical areas of hospitals and clinics.

Healthcare workers over 60 years old who have comorbidities or those who are pregnant, should be removed from direct contact with COVID-19 patients.

4. Telehealth first

During the pandemic, healthcare systems have had to adjust in the way they triage, evaluate, and care for patients, using methods that do not rely on in person services. A telehealth (or virtual) first-approach helps provide the necessary care to patients, while reducing COVID-19 transmission risk to patients and healthcare workers, preserving personal protective equipment (PPE), and minimising the impact of patient surges on facilities[15][16].

Through telehealth or virtual provision of care, acute care of patients in the community and hospitals can be properly managed and prioritised. This will limit overcrowding and access blocking within our emergency departments, general practices and urgent care facilities. Given the required increased vigilance and workload, it is unsustainable for the hospital emergency departments, general practices and urgent care facilities to place their patients and themselves at increased risk of infection. Reducing the potential for crowded environments where patients with varying health needs congregate, will reduce the likelihood of harm. Providing patient care in the community as much as possible is the best outcome for New Zealanders, to reduce the risk of overwhelming our hospitals (see ACEM's Access Block statement). It is essential that there is a shared awareness and accountability from other specialties and executives to manage patient flow across

[9] https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/when-and-how-to-use-masks
[10] Coghlan, B., Crabb, B.S., Hellard, M.E., Majumdar, S.S., Saul, A., Scott, N. and The Peter Doherty Institute for Infection and Immunity. 2020. Victoria's response to a resurgence of COVID-19 has averted 9,000-37,000 cases in July 2020 (unpublished)
[11] https://www.rnz.co.nz/news/national/423355/covid-19-travel-restrictions-masks-on-flights-as-measures-take-effect
[12] https://theconversation.com/ppe-unmasked-why-health-care-workers-in-australia-are-inadequately-protected-against-coronavirus-143751
[13] Safer Care Victoria (SCV). 2020. Learning from healthcare worker COVID-19 infections acquired through occupational exposure. July 2020, Issue 1 (unpublished)
[14] Chu DK, Akl EA, Duda S, Solo K, Yaacoub S, Schünemann HJ, El-harakeh A, Bognanni A, Lotfi T, Loeb M, Hajizadeh A. Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis. The Lancet. 2020; 395(10242) 1973-1987
[15] https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html
[16] https://www.telehealth.org.nz/

our DHBs, while recognising the extra work that will be taken up by medical services within the community and hospital environments.

When using or accessing telehealth, the following should be considered:

a. Patients' choices

Patients should be advised to:

i. call Healthline for advice, or
ii. contact their general practitioner (GP) by phone, who will triage them to:
    1. a phone or video (virtual) consultation
    2. an in-person appointment, or
    3. direct them to the most appropriate healthcare service.

b. Continuation of acute care

The whole health care system is faced with sustaining additional requirements related to COVID-19, maintaining patient, staff and public safety, while continuing to care for patients with non-COVID-19 health care needs. Where possible, telehealth access to hospital specialists and clinics should also be made available, to ensure that acute and ongoing care of patients continues as efficiently as possible. Amidst the uncertainty of when, or if, a vaccine will be available, ongoing and chronic healthcare needs should be addressed accordingly and not be allowed to accumulate, as we are uncertain how long this pandemic might last.

We are also concerned for our large proportion of aging doctors, nurses and allied health staff working in our healthcare services in general practice, given age is a COVID-19 risk factor. These professionals will benefit from a telehealth first-approach, being able to provide the essential continuity of care for their patients and continuing to support the whole system.

5. Surveillance programme (swabbing)

In addition to strict border control with managed isolation and quarantine facilities, and swift contact tracing including the COVID-19 Tracer App, we commend the Government on the rapid increase in test numbers since the COVID-19 resurgence. We would advocate for an ongoing nationwide, economical, sustainable surveillance swabbing programme to meet the Ministry's stated goal of 4000 to 5500 community surveillance swabs per day, if and when the current outbreak abates. The programme should include DHB targets weighted for population and quarantine demographics.

6. Improved communications and advanced warning of lockdown status

We are willing and able to support the Ministry's communications efforts to ensure our members are kept up to date with the latest situation. Updates must be nationally consistent, timely and in line with what is happening at the front line if they are to be effective. We will continue to work with the Ministry to help address some of the messaging issues identified during in the earlier surge.

We also encourage the Ministry to strengthen its messaging to DHBs and other organisations to ensure its policies are followed accordingly.

7. Funding

Primary healthcare is at the core of healthcare provision in New Zealand and many primary health services outside of hospital suffered financially in making their services safe for patients and staff while trying to contend with COVID-19 and continue business as usual during the first outbreak. Changing patient demand and models of care have had a serious financial and wellbeing impact on all health staff in general practice and urgent care. It highlighted the unsustainability of current primary care funding, for changing models of care, and this needs to be urgently addressed.

We are signalling that general practice and urgent care funding will need careful, realistic consideration to enable the rapid and necessary response to current and future COVID-19 outbreaks. Financial constraints should not hamper our response to COVID-19 or require a part of the health sector to work under financial pressure while performing necessary work to keep our health system and nation safe.

Background

ACEM is the peak body for emergency medicine in Australia and New Zealand, responsible for training emergency physicians and advancement of professional standards. www.acem.org.au

RNZCGP is the professional body and postgraduate educational institute for general practitioners (GPs). www.rnzcgp.org.nz

RNZCUC is responsible for training doctors and maintaining professional standards in urgent care. www.rnzcuc.org.nz