



# New Zealand research and international perspectives on the pandemic

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When the rest of the world currently feels far away, the Journal of Primary Health Care is delighted to platform a qualitative, empirical study by our colleagues in Sweden.<sup>1</sup> Despite our contrasting approaches to COVID-19, their description of the impact of COVID-19 in Stockholm resonates with aspects of our own experience in New Zealand, often in unexpected ways. General practitioners (GPs) in New Zealand were not alone when demand for our services suddenly tailed off; in Stockholm there was a 25% reduction in patient consultations. This hiatus in patient contact has fermented a sense of unease in both our workforces and although it is still too early to determine a trend of morbidity and mortality resulting from it in Stockholm, the long-term impact of late presentations on the health of our nations is likely to be insidious.

A second publication in this edition of the JPHC describes a survey of behaviours that influence mask-wearing in New Zealand.<sup>2</sup> It finds that socially-minded people have declined to wear face masks out of concern for other people, who may need one more. This altruism is likely to be recalibrated by increased use of fabric-based masks, but similar acts of kindness might conceivably deter patients from seeing a GP. While anecdotal reports from the front line of general practice suggest patient numbers have returned to pre-COVID levels at many practices, this is not universal. Perhaps it is time for us to audit the impact of COVID-19 on consultation numbers. A campaign to dispel assumptions made by a kindly public, such as 'GPs are too busy doing more important things', might be the possible outcome of a survey.

Sadly, the Rosewood cluster in Christchurch showed that our aged residential care (ARC) units are just as vulnerable as they are everywhere, but shortages of personal protective equipment (PPE) were not implicated as the cause of it (incorrect use of PPE was). An inquiry is currently underway in

Stockholm because that was their reality. The authors' prescient observation that poor infection control in ARCs '*highlighted how actions or inactions by one sector or service impacted others, often later in time and in unpredictable ways*' is most evident at the borders of New Zealand and Australia. In July we collectively winced as the Australian state of Victoria painfully unravelled because of compliance issues in their quarantine facilities. In August our own good luck ran out.

With few credible alternatives, actions or inactions taken either at the border or in quarantine facilities are likely the origin of a new outbreak (outbreaks?) in Auckland, 102 days after last known community transmission. The revelation that staff who work in high-risk facilities were not being routinely screened for COVID-19 has brought the management of our borders and quarantine system under scrutiny for the second time in recent months. The first time in June was when two international arrivals were permitted to leave their Auckland quarantine facility for compassionate reasons without first being tested, and were later confirmed to be infected with COVID-19 having travelled the length of the North Island.

Learning reactively from mistakes that are proactively avoidable seems a high-risk strategy during a pandemic. Mistakes lead to lockdown. Lockdown incubates public fatigue and contributes to a growing sense of delaying the inevitable. Views expressed by groups like Plan B,<sup>3</sup> who suggest a background level of community transmission in this country is less detrimental than the pursuit of eradication, consequently gain traction.

But as we learn more about COVID-19 it becomes obvious that some populations in New Zealand stand to lose more than others by agreeing to cohabit with it. We are just beginning to understand the magnitude of poorer outcomes in obese populations. In New Zealand, 66.5% of Pasifika, 48.2% of

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Māori and 29.1% of European adults are obese (New Zealand Health Statistics 2018/19). A cautious approach to the pandemic in New Zealand has insulated these populations from harm while evidence of their vulnerability has emerged from parts of the world where the pandemic is less well controlled, validating a strategy that initially quarantined the genie to its bottle. The onus is now on groups like Plan B, who are performing an important function by giving an alternative view, to explain how shielding a third to a half of the working population is economically preferable to elimination.

The views and attitudes survey of facial coverings included in this edition of the Journal does hint at the central role belief is likely to play for the foreseeable future. People who believe face masks work tend to wear them. People who believe face masks do not work are unsurprisingly less likely to. Politicians contend with increasingly nuanced public beliefs, fed by internet misinformation. Pushing an unwilling public too hard could undermine efforts to contain the virus. Not pushing hard enough will clear the way for it. With COVID-19's concerning foothold in the Pasifika community and the sad passing of former Cook Island Prime Minister and eminent Auckland GP, Dr John

Williams, whose infection with COVID-19 remains worryingly unconnected to all other current cases, elements of a second outbreak with potential to be worse than the first are already in place. Lockdown measures are being relaxed while infected individuals continue to be found with apparently no connection to the main cluster. We will hope that QR readers and contact tracing has matured sufficiently to chase the tail of infection in New Zealand.

In the meantime, it might be wise to hold a belief that *'if this might work, let's just do it'*. If wearing a mask when we go to the supermarket might help, then let's do it. If downloading the COVID app might help, then just do it. If we have a runny nose and having a swab might help, let's just do it.

## References

1. Ohrling M, Øvretveit J, Lockowandt U, et al. Management of the emergency response to the SARS-CoV-2 (COVID-19) outbreak in Stockholm, Sweden, and winter preparations. *J Prim Health Care* 2020;12(3):207–14.
2. Gray L, MacDonald C, Tassell-Matamua N, et al. Wearing one for the team: views and attitudes to face covering in New Zealand/Aotearoa during COVID-19 Alert Level 4 lockdown. *J Prim Health Care* 2020;12(3):199–206.
3. A balanced response to COVID-19. [cited 2020 September 1]. Available from: <https://www.covidplanb.co.nz/>.