



COVID-19: New Zealand's Urgent Care Story

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Like the rest of the world, New Zealand (and more particularly its healthcare system) has been changed, perhaps irrevocably, by COVID-19. Despite a relatively small direct effect on the population (0.06% infected, half of which were identified and isolated at border) with 0.0004% deaths¹ (including one physician), the effects on primary care have been substantial.

The Beginning

New Zealand clinicians were first notified of the Wuhan cluster in January 2020. By the beginning of February 2020, the threat was clear. Public health authorities immediately declared the disease reportable, although testing at that time could only be done with central approval.

In early February of that year, tourists who had been repatriated from the Diamond Princess cruise liner in Tokyo were quarantined on a NZ defense base. A UC physician from the nearest clinic volunteered to provide medical care to the passengers, who were eventually discharged without any cases found.

As local COVID-19 cases gradually emerged in February and March, screening was established around the country, with increasing use of separate rooms and personal protective equipment for suspicious cases. A 7-week nationwide lockdown was instituted in late March in response to exponentially increasing cases. Only essential services continued, with tight travel and distancing restrictions put in place.

This triggered a major shift in patient care as the College of General Practitioners called for a move to telehealth for their physician members.² The effect of this was that a large number of patients who needed a face-to-face consult were channeled to urgent care, as were the large numbers of international vis-

itors trapped in country. Many of the international patients needed repeat prescriptions, often for medications not available in New Zealand.

Volumes in emergency departments dropped in response to a message to keep clear for COVID-19. Overnight the nation's UC centers became the most visited locus for physical evaluations. Compulsory mask wearing and separation of patients was implemented immediately, and testing centers sprung up overnight in car parks.

Assessment and treatment of symptomatic patients was more of a problem. UC centers had not been constructed with a need for isolation in mind. While EDs had been built with isolation/negative pressure facilities in response to the 2003 SARS outbreak, UCs lacked these capabilities.

Several approaches were used to address this shortcoming, with patients initially being assessed in their cars (a strategy taken from the response to New Zealand's 2019 measles outbreak). Some clinics had a room available adjacent to a separate entrance while others used temporary buildings for suspect cases. Telephone triaging was used with mixed success to separate streams of respiratory/febrile cases from others.

PPE (such as gloves, masks, and gowns) was initially in short supply. While government stocks were released relatively quickly, N95 masks were not distributed to community facilities because of doubts surrounding proper fit testing. Thankfully, no serious shortages of PPE occurred otherwise.

Vaccination

Immunization has proceeded at a slower pace compared with Northern Hemisphere countries, with a program using the Pfizer vaccine commencing in February 2021. Clinical staff were mostly able to complete courses of immunization by June 2021, although an open letter in May 2021 from 32 doctors to the government questioned the legality of registering the vaccine under national pharmaceutical regulations.

Although other vaccines are now available (AstraZeneca) or approved (Janssen, Novavax) only the Pfizer vaccine has



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been widely deployed, as New Zealand’s AstraZeneca supplies have been rerouted to other Pacific Island nations.

The wider epidemiological effects of interest include a fall in all-cause mortality³ and winter respiratory illnesses during 2020, followed by a supernormal RSV surge in 2021, which was attributed to two cohorts of infants who had not previously been exposed to this virus.⁴

COVID-19 and the Future of UC in New Zealand

Higher awareness about infectious disease preparedness due to the pandemic and the 2019 measles outbreak has proven that urgent care centers need to be designed with facilities to isolate potentially infectious patients from others. Accreditation of urgent care facilities in New Zealand has been largely under the purview of the Accident Compensation Commission. This organization pays for treatment, rehabilitation, and financial support of accident victims and has been instrumental in setting standards for UC facilities.⁵ However, these have largely focused on injured patients rather than those with infectious illness.

In the future, a separate entrance and treatment area for infectious patients would be prudent in the design of all UC centers.

Could this also mean a long-term move of acute and particularly infectious patients to UC centers? COVID-19 has also changed the landscape for the other part of primary care—general practice, which was already struggling with an aging workforce, increasing compliance issues, and physician shortages.⁶ In many parts of the country, waits for primary care appointments had been long. The addition of COVID-19 has exacerbated the situation as many general practitioners have been persuaded to retire earlier than originally planned. Along with the move of much of general practice to telemedicine, this has shifted a greater load of acute presentations to urgent care and emergency departments. The inability to obtain primary care appointments has also led to the increasing use of urgent care for routine consultations such as repeat medications.

Postscript

As of August 2021, New Zealand had entered its second lockdown due to the arrival of the Delta variant. Unfortunately, immunization has only been achieved in approximately 20% of the eligible population.⁷ The most recent wave of infections has exposed the slow progress of immunization and limited capacity (particularly in intensive care units) to safely care for victims too unwell for community care. As we enter this phase, the topic of strategy is being debated, as “elimination” seems less practical in favor of the more pragmatic “containment” or “mitigation” approaches.

Whatever the future holds, it looks as if urgent care will play an increasingly integral role in New Zealand’s healthcare

landscape. Whether this is understood by policy makers to whom the specialty has been largely overlooked⁸ remains to be seen. ■

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If so, this is the place to be. Propose a topic to us via email to editor@jucm.com. We’ll get right back to you to discuss it, and offer assistance along the way.

We look forward to hearing from you soon.