Media Statement: 17 December 2021

OMICRON COVID response must be immediate, comprehensive and sustainable

The Government's announcement of an extra $644 million for hospital upgrades (including 23 new Intensive Care and High Dependency beds) is welcome, but it will not help the potential 45,000 COVID positive patients per week that could be isolating in the community by March 2022. That's according to GenPro (The national association for providers of general practice services), whose objectives include improving the health of the population of New Zealand and advocating for high-quality, accessible and equitable patient care.

GenPro's Chair, Dr Tim Malloy, said "Early evidence from South Africa, where the Omicron variant was first detected, shows that Omicron infections appear to have less serious symptoms than previous COVID variants and result in fewer hospitalisations. That means our COVID response should immediately shift to ensuring our front-line, community based general practice teams are resourced to be able to manage the inevitable surge that is coming.

"Omicron is already in New Zealand and if we look at what is happening with COVID cases in the UK – a country now with broadly similar vaccination rates to ourselves – we need to plan for, on average, each general practice in New Zealand providing tailored daily care and support for over 45 of their patients, plus their immediate whānau, who will be isolating at home with a COVID positive infection".

For many months GenPro has been offering to work with the Ministry of Health to develop a robust community response plan and has been seeking clarification of their responsibilities and the availability of the resources which will be required. "Only in November 2021 did we have sight of the Ministry's draft proposals for managing COVID positive patients in the community, and even then there were essential patient care requirements missing from the plans and significant patient care expectations that simply would not be able to be provided due to lack of funding. We provided immediate and detailed feedback on the draft proposals in November but have heard nothing since", said Dr Malloy.

The Ministry of Health's own COVID data* for the period from 26 February 2020 to 16 December 2021 shows that only 5% of New Zealand's 13,238 COVID positive cases (656 cases) have needed hospital care and with less than half of 1% requiring ICU care (54 cases).

GenPro emphasises that, to date, New Zealand's COVID response has primarily been undertaken in front-line community and general practice settings and any direct pressure on hospitals has been limited. It also says that the future response will similarly be reliant upon general practice and community health professionals to continue the vaccination (including booster) programme, testing, swabbing, and now, managing the significant rise in COVID positive patients who will mostly need community care rather than hospital admission.

Dr Malloy advises that the Government's response seems to underestimate the predictable community impact of COVID and Omicron whilst surprisingly committing significant funding to non-COVID priorities during the pandemic "..the Government is putting hundreds of millions of dollars into re-structuring layers of health management whilst essential front-line services are being underfunded. The system simply cannot provide services for which there is insufficient funding, and for which we have been unable to plan logistically – for example, we are on the verge of the Christmas and New Year holiday period and staff leave has already been booked for health professionals who are already worn out by the mammoth vaccination and swabbing effort that has been undertaken on top of business as usual. Yet Omicron is already here and we can no longer say that we are protected by our closed borders".

GenPro is concerned that the impact of the lack of agreed plans and required funding will mean that COVID positive patients will be referred directly for hospital-based care and support which is neither the most convenient for the patient nor the most efficient for the system.

ENDs

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Information for Editors:

* The Ministry of Health's COVID case data is available on-line at https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-case-demographics#hospitalisations

1. The UK recorded 88,376 new daily cases on 16 December 2021 for a population of 67.2 million. New Zealand's population of 5 million is 7.4% that of the UK. 7.4% of the UK's daily cases would be 6,540 cases per day or 45,779 cases per week. The first Omicron cases were detected in the UK on 27 November 2021.

2. GenPro's November 2021 feedback to the Ministry of Health (as part of a collective response with the following partners forming the Contracted Provider Caucus – The Royal New Zealand College of General Practitioners, the New Zealand Medical Association and, the New Zealand Rural General Practice Network) regarding the Ministry's proposals for management of COVID positive patients in the community, included the following points:

   Primary Care Clinical Model:
   a. Clarification is required with regards the co-ordination role to connect with, and oversee social care needs, liaison with Public Health etc
   b. Clarification is required with regards who will be responsible for delivering, collecting and cleaning pulse oximeters which are to be provided to COVID positive patients
   c. Households where a COVID positive patient is isolating will likely have other residents also in isolation (whether they are COVID positive or not). All residents therefore become high-risk and will require clinical monitoring and support. In order to allow sufficient time and to respect issues such as patient confidentiality, each patient/resident should be assessed/supported through their own funded virtual consult
   d. Follow up check – we know that practices will also be getting discharge summaries from hospital to follow-up COVID patients who were admitted – the follow-up consult is likely to mirror the initial assessment and should be funded as such.

Medical Complexity:

a. By definition, COVID positive patients are high-risk and subject to significant clinical deterioration within very short timeframes. Therefore, we would advise that:
b. The risk to continuity of operations within general practice must be acknowledged and proactively managed – particularly with regards to:
    i. The risk to practice staff and non-COVID patients of potential contact through practice-based face-to-face consultations
    ii. The risk to GPs and their colleagues following a home visit for a COVID positive patient (or a member of their whānau)
    iii. The pressure on business as usual due to capacity and workload pressures upon general practice
c. The limit of one claim per patient, per day is clinically inappropriate and doesn't acknowledge that the patient's condition may change rapidly and the practice will also receive incoming calls for assistance in addition to the outgoing assessment and surveillance calls
d. A proportion of the standard virtual monitoring consults will require escalation and additional clinical input (without the need for a high-risk face-to-face consultation). Therefore, an additional fee is required for a same-day escalation consult. We believe this is likely to be a circa 20 minute, GP-led virtual consult.

High-Needs:

a. There is a significant need for equity of access and service provision for high-needs patients. In this regard, we would advise that:
b. The high-needs premium should be a minimum of 50% to recognise the additional workload/time commitment required
c. Where a patient's condition deteriorates and the need for an ambulance is indicated, it is important that the principle of "free care" is maintained, especially for high-needs patients, who may otherwise be deterred due to existing ambulance charges. It would be helpful to clarify how ambulance journeys for COVID positive patients will be funded

Service Alignment:

a. It would be helpful to clarify the expectations and associated fees for general practice service provision on behalf of un-registered patients – who will, by definition, require longer consult times due to the lack of an existing relationship as well as the lack of immediate access to the patient's history
b. The suggestion that after-hours arrangements be co-ordinated on a DHB-by-DHB basis is of significant concern. National consistency is required in this regard and is important for many reasons, including clarity for patients, the avoidance of a postcode lottery, minimisation of bureaucracy/administration
c. Clarity and appropriate funding is required for the provision of ACC care for COVID positive patients isolating in the community – this is particularly important to help avoid all such patients simply presenting at the nearest ED. One option may be for the Ministry of Health to fund all care for COVID positive patients isolating in the community.

Fee Levels:

a. Several of the fees proposed do not reflect either the time commitment required or the service cost. Based upon feedback from providers already supporting COVID positive patients in the community, as well as clinical opinions of the likely consult content/time, we have re-estimated the consult times and actual costs.