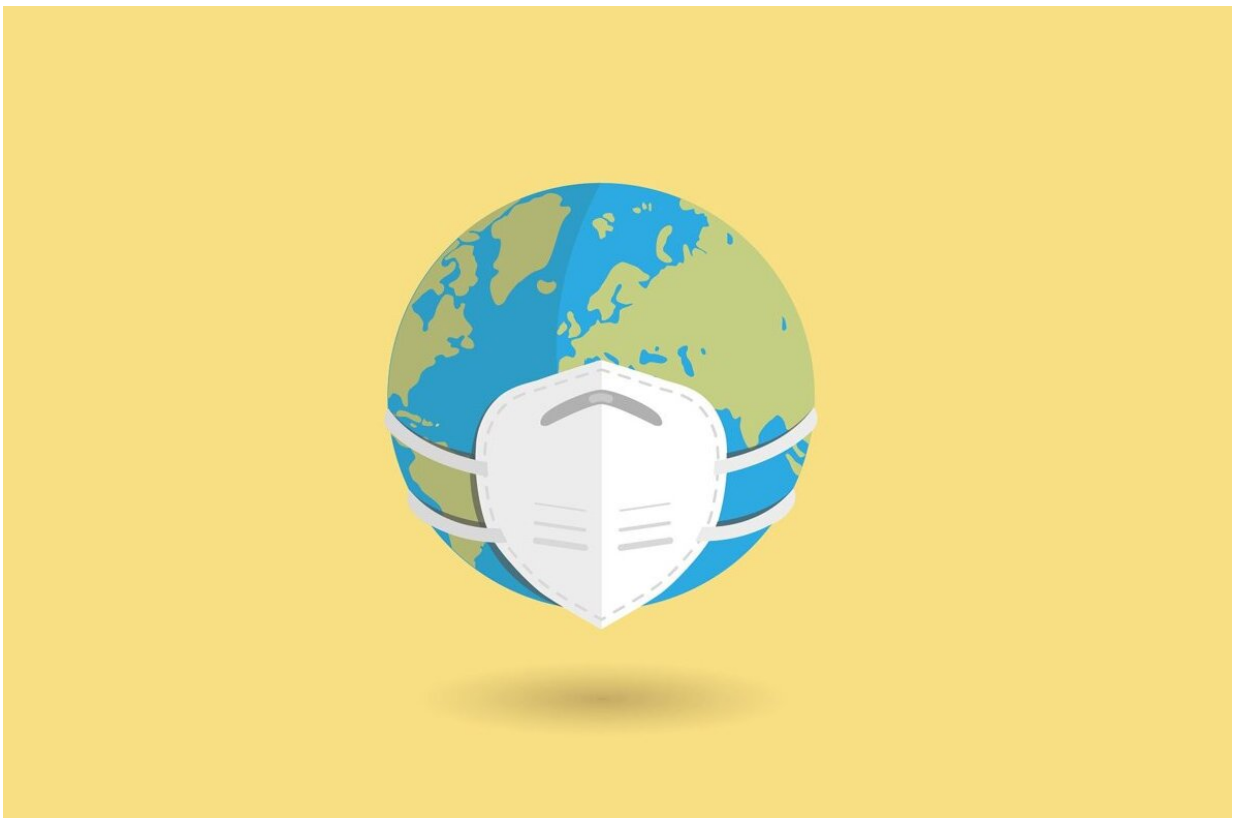


# A pandemic that won't go away—as COVID enters its fifth year, NZ needs a realistic strategy

February 27 2024, by Michael Baker, Amanda Kvalsvig and Matire Harwood

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February 28 marks four years since COVID-19 was [first reported](#) in

Aotearoa New Zealand. Many of us are probably surprised this virus is still causing a pandemic.

The World Health Organization refers to COVID-19 as a [continuing pandemic](#). As Scientific American put it recently, it "has been the elephant in every room—sometimes confronted and sometimes ignored but always present".

It wasn't meant to be like this. The 1918 influenza [pandemic swept through New Zealand](#) in eight weeks, killing 9,000 people—almost 1% of the population. Then it was gone, returning as a new seasonal flu virus.

In doing so, it defined how pandemics were expected to behave. This model was written into pandemic plans and collective thinking across the globe.

But COVID is [still circulating](#) four years after New Zealand reported its first case, and more than two years after the omicron variant arrived and infection became widespread.

Constantly present, it is also occurring in waves. Unexpectedly, the current [fifth wave](#) was larger than the [fourth](#), suggesting we can't rely on the comforting assumption that COVID will get less severe over time.

## Unpredictable evolutionary shifts

These waves are driven by the interaction of the organism (SARS CoV-2 virus), the host (human characteristics such as immunity and behaviour), and environmental factors (such as indoor ventilation).

Continuing viral evolution is a major contributor to the changing dynamic. The virus has demonstrated an ability for large, unpredictable

evolutionary shifts that dramatically alter its genome and spike protein.

The result is an enhanced ability to evade prior immunity and infect more people. This jump was seen with the highly mutated [BA.2.86 subvariant](#) in mid-2023.

Its offspring, JN.1, has acquired additional changes and is causing such a wave of new infections it could potentially be the next variant of concern, with its own Greek letter. It is now driving epidemic increases across the globe, [including in New Zealand](#). This dominance by a single subvariant takes us back to the first year of omicron in 2022.

## Under-counting the pandemic impact

The pandemic continues to have a large, visible health impact. It is a leading cause of serious illness and death, mainly in older populations and those with existing long-term health conditions.

In 2023, it caused more than [12,000 hospitalizations and 1,000 deaths](#) in New Zealand.

But COVID-19 also has an important and largely unmeasured [burden of disease](#) as the cause of long COVID, which may become its biggest health impact. A growing number of studies are describing an estimated incidence of long COVID of 5% to 15% of all infections.

For example, a recent [large study](#) of almost 200,000 Scottish adults reported that, after adjustment for factors that might confuse the results, long COVID prevalence following an infection was 6.6% at six months, 6.5% at 12 months, and 10.4% at 18 months.

These findings illustrate an important feature of long COVID: recovery can take two years or more, with [symptoms that fluctuate](#) over time.

## An integrated respiratory disease strategy

New Zealand now needs a strong, integrated response to COVID-19 and other respiratory infections.

The major pandemic interventions have not changed: vaccination, public health and social measures to prevent infection, and antivirals for more vulnerable groups. The evidence has firmed up that long COVID risk is [reduced by vaccination](#), but research is less certain for antivirals.

But growing pandemic complacency from political leaders and the public has changed things. Some of this apparent indifference can be put down to understandable fatigue with response measures. But it remains dangerous in the face of a continuing pandemic.

One way to keep a focus on prevention and control would be to include these measures in an [integrated respiratory infectious disease strategy](#). This would combine COVID-19 control measures with those used to protect against influenza, [respiratory syncytial virus](#) (RSV), and other respiratory infections.

Measles could be added to the list, given the rising [threat to New Zealand](#) from a global resurgence of the disease.

This [integrated strategy](#) would include vaccination, promoting testing and self-isolation when sick, and measures to reduce transmission in critical indoor environments such as health care, public transport and education settings.

Such a program would need to be supported with community engagement, education, surveillance and research.

Structural inequalities mean Māori, Pacific peoples, and those living in

relative deprivation, are less vaccinated, less protected from infection, less tested and less likely to have antivirals.

Consequently, they are more likely to be hospitalized and [die from COVID-19](#). These inequities are currently not being systematically tracked and acted on.

## **Ignoring it won't make it go away**

As we enter the fifth pandemic year, we need a change in thinking about COVID-19. This infection has [pathological features](#) in common with the other severe coronaviruses (SARS and MERS).

It is wishful thinking to imagine it will suddenly transform into a common cold coronavirus. As a recent [review article](#) concluded:

"Transition from a pandemic to future endemic existence of SARS-CoV-2 is likely to be long and erratic [...] endemic SARS-CoV-2 is by far not a synonym for safe infections, mild COVID-19 or a low population mortality and morbidity burden."

In the face of this continuing pandemic threat, we need a response that is evidence-informed rather than evidence-ignored.

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