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Accessing primary healthcare during COVID-19: health messaging during lockdown

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ABSTRACT

Accessing healthcare during a disaster matters for the well-being of people and communities. This article explores healthcare messaging about General Practitioner (GP) services for non-COVID-19 health concerns during the Level 4 lockdown in Te Papaioea (Palmerston North), Aotearoa New Zealand. Messaging from Government, media and local GP clinics were analysed to understand how people were advised to seek care for non-COVID-19 health concerns. We found inconsistencies in these communications, ranging from messages to not attend healthcare services because of possible COVID-19 surges, to messages with vague, or lack of, information. Government messages did include advice for seeking general healthcare, but this was largely rendered invisible due to the focus on 'staying home, saving lives'. Media messaging was similarly influenced by these Government directives. Few GP clinics had websites, and few provided information about accessing general healthcare services. Clinics also lacked up-to-date telephone messages about seeking healthcare for non-COVID-19 symptoms and illnesses. All three sources neglected the cultural, social and contextual diversity of the local audience. We recommend that communication during disasters should be clear, concise and consistent. Further, GPs should be supported to have websites and telecommunication platforms. All communications should be inclusive and aim to reach diverse audiences.

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Introduction

Access to healthcare for health conditions is critical for people and communities to ensure collective well-being in both ordinary and extraordinary times. When disasters occur, such as pandemics, concerns about health can shift predominantly to managing

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the health issues that arise from the crisis, and non-disaster health conditions can be possibly side-lined or deferred. Still, people need to make decisions on how to manage their existing or arising aliments (e.g. diabetes, heart conditions, sexually transmitted infections, etc.) in disaster contexts. During adverse events, such as a deadly pandemic, access to healthcare may be constrained, and decisions on accessing healthcare are likely to be based on information conveyed by sanctioned bodies, such as health agencies. At these times, healthcare communication needs to target audiences in culturally, socially and contextually responsive ways (Burger et al. 2013; Shevellar and Riggs 2015; Tierney 2019). This article explores how access to healthcare services was communicated for non-COVID health conditions during the COVID-19 alert level 4 lockdown in Palmerston North, Aotearoa New Zealand.

COVID-19 crisis in Aotearoa: access to GP care

On 23 March 2020, the Aotearoa New Zealand Government issued an Epidemic Notice, under Section 5 of the Epidemic Preparedness Act 2006 (New Zealand Government, 2020b), sanctioning government agencies to respond immediately to the evolving pandemic. This directive aimed to prevent the spread of COVID-19 through avenues such as restricting border entry, revoking travel visas, enforcing quarantine measures, and limiting mobility. The Epidemic Notice served a two-day warning of a full-scale all-of-country Alert Level 4 lockdown. Under this alert level, all public gathering places and businesses were closed, except for those considered to be essential services, emergency services, or transportation services for utilities and goods. All people not engaged in these workforces were instructed to remain at home in secure physical 'bubbles' for four weeks. Due to the unpredictable trajectory of COVID-19 many secondary healthcare services, such as hospitals, were reprioritised to ensure they could be available in case of a surge in demand from COVID-19 cases (New Zealand Government, 2020a). As a result, many elective surgery procedures and hospital out-patient consultations were postponed, with more routine out-patient consultations held by telephone or on-line (McGuinness and Hsee 2020). The speed of initiating this Alert Level 4 response led to confusion and some breaches of these requirements (Biddle 2020; Carroll 2020; NZ Herald 2020c). There was debate about the value of face masks from the public and no clear directives were issued on mask wearing at that time from the Ministry of Health (Gray et al. 2021). There was also general confusion around safety in the workplace and distancing rules, and anxiety over how long the measures would be in place (Elers et al. 2021).

Alert Level 4 also disrupted primary healthcare service provision. Pharmacies remained open but limited entry to one person at a time, cautionary public health COVID-19 messages were placed strategically, and in some places, large plastic protection barriers were fitted to separate staff and customers. Prescription procedures changed to faxing only, and there were reports of medication stockpiling and concerns of medications shortages (Hall et al. 2020). GP services were directed to reduce face-to-face visits, and health consultations were triaged by telephone, with those deemed less urgent referred to a nurse or a follow-up GP phone (or video) consultation (Henry 2020; NZ Herald 2020b; New Zealand Government, 2020c). This 'forward triage' process of sorting patients before they arrived at a clinic, facilitated a screening system to prevent unnecessary risk for staff, other patients, and the community of the

spread of COVID-19 (Dovey 2020; Hollander and Carr 2020). This was important for people who were more susceptible to the effects of COVID-19, such as older adults.

Forward triage and tele-health required patients and healthcare professionals to utilise tele-medicine formats, such as telephone or video-conferencing (Atlas et al. 2020; Dovey 2020; Hollander and Carr 2020). This form of primary healthcare delivery assumed that people had ready access to telephone services, the internet, or smart devices with camera capability (e.g. tablet, phone, computer, watch). This process largely disregarded groups with limited resources, such as those who are impoverished and disadvantaged due to insecure employment, housing and food, and those who do not engage with technology, such as some people with mental distress (DeBruin et al. 2012; Fish et al. 2017; Dovey 2020). While research has indicated that 91% of New Zealanders have access to the internet, it is recognised that people living in social housing, people with disabilities, and Pasifika students are disadvantaged with only around 69% having access. Older adults, unemployed, Māori, and Pasifika also have much lower rates of access or the means to access the internet with a device (Grimes and White 2019; Gray et al. 2021). Similarly, Atlas et al. (2020) found the use of mobile technology amongst octogenarian groups was lower than that of the general population, and that Māori were less likely to use cell phones or have access to the internet. It was unclear if these groups received any public health warnings or general health messages because text and online communication were not necessarily viable for them. Elers and colleagues (2021) interviewed people from Māori, Pasfikia and refugee communities in Aotearoa in April 2020 and confirmed that they experienced language barriers, confusion, and lack of access to reliable means of digital communication during the Level 4 lockdown period. Elers et al. (2021) suggest health communication measures failed to acknowledge the struggles of already marginalised communities reinforcing health inequalities.

New technologies are playing an increasingly important role in disasters but traditional media, such as television and radio, remain important (Tian et al. 2009). COVID-19 was unique in that newspaper deliveries stopped and people could only read on-line articles during level 3 and 4. This had implications for people not familiar with technology who rely on more traditional methods for accessing official messaging and those in rural areas with poor internet connectivity (Fuchs 2020). These limitations may be more problematic for these groups given that people often rely on multiple sources for effective information seeking (Tu-Keefner et al. 2017).

Media messaging during an emergency

It is now well recognised that precise and clear communication about health risks and safe practices during a pandemic is crucial, particularly when an entire country is housebound and reliant on the directives and guidance of officials (Kahan et al. 2003; King et al. 2018). During all types of disasters, good public health messaging should use simple language that is more readily recalled (Fish et al. 2017). Messages should be inclusive and tailored to the socio-demographic characteristics of health 'consumers'. Messages also need to be adaptable to the particular emergency or disaster situation as it evolves (Bannor et al. 2017; King et al. 2018; Perry et al. 2020). Throughout extraordinary events, research suggests that people trust information that presents basic facts provided by credible sources (Tu-Keefner et al. 2017; Goggin and Ellis 2020).

Under Alert Level 4, New Zealanders were saturated with health messages from media sites (television, radio, social media, advertising) imploring them to seek health advice if they exhibited any symptoms of COVID-19. People were encouraged to seek advice primarily through phone calls to either the national Healthline or the person's GP. While this COVID-19 healthcare messaging was imperative, it appeared to generate uncertainty about what actions to take if people were experiencing other non-COVID-19 symptoms. Visits to hospital Emergency Departments and GP clinics in Aotearoa dropped by 50%–84% in some regions, just three days after Alert Level 4 came into effect, suggesting that this could result in patients presenting later with more severe progression of non-COVID-19 illnesses (General Practice New Zealand 2020; Martin 2020; Witton 2020). Hence, while the COVID-19 associated messaging was quite clear, stay at home, it was less clear how non-COVID-19 health concerns were to be addressed during lockdown.

This article aims to illuminate how messages about healthcare provision were communicated around the time of the COVID-19 Level 4 lockdown. We take the regional city of Palmerston North as a useful case study to critically analyse the way in which people in that area were informed about healthcare options, with a particular focus on non-COVID-related messaging. We examine how this was communicated by Government channels, in media reports, and by local GP services.

Method

A team of health and disaster researchers from universities University in Palmerston North, Auckland and Wellington chose Palmerston North as the case study for this research because it is demographically representative of the wider Aotearoa population (see Table 1), and it offered a manageable region within which to locate GP data. Palmerston North has a population of 84,000 people with the mean age of 34 years (Statistics NZ 2018).

Data were gathered between April 14 and May 19, 2020. Public health messaging emanating from Government sources about healthcare during the Level 4 COVID-19 lockdown was retrieved from the New Zealand Ministry of Health website, the official COVID-19 Pandemic website, and transcriptions of the Post-Cabinet Press Conference 'Daily Briefings' from the New Zealand Government and the Director-General of Health. We searched the official COVID-19 Pandemic website and the Post-Cabinet Press Conference Daily Briefings transcripts using the key terms: 'GPs', 'Emergency Departments', 'accessing healthcare', and 'non-COVID symptoms'. Additional information was gathered from the General Practice New Zealand website. Altogether these searches identified seven relevant documents for analysis.

We also conducted systematic online searches to identify relevant online content offering advice about healthcare under the pandemic lockdown conditions, using the following key phrases: 'accessing healthcare during a pandemic', 'seeing a GP during lockdown', 'can I see my GP during lockdown, NZ', 'seeing a GP for non-COVID symptoms', and 'can I see my GP for non-COVID illnesses'. These search parameters produced documents from a variety of sources, including online media articles, and health advisory websites (such as nib health insurance). These documents were scanned and restricted to those with New Zealand content, producing 122 documents. These documents were then analysed for content that was specifically related to accessing healthcare for non-COVID-19 related symptoms.

Table 1. Demographics of Palmerston North in comparison with Aotearoa New Zealand.

Demographic	Palmerston North %	Aotearoa %
NZ European	71.5	70.1
Māori	15.3	16.5
Pasifika	3.7	8.1
Te Reo Māori Speaking	4.4	4.0
NZ Sign Language Speaking	0.9	0.5
No access to telecommunications	1.1	1.1
Access to cellphone /mobile	92.3	91.9
Access to the internet	86.1	86.1

Note: Taken from 2018 Census data (Statistics NZ 2018).

Finally, we identified a total of twenty GP clinics in Palmerston North (see Table 2), and gathered data from their websites, where this was available. Gathering website data involved taking screenshots of all pages that included messaging specifically tailored to COVID-19 lockdown conditions. We also telephoned all twenty clinics during their after-hours times (11 am–12 pm, Saturday), and recorded and transcribed their answer service messaging.

Analysis

Analysis was a form of qualitative content analysis (Hsieh and Shannon 2005). Data were grouped and analysed by source – Government documents, online material, and GP practice material. Government and online data were then sorted by date to create a timeline of the messages being delivered to the public across the Level 4 lockdown period. The two lead researchers repeatedly read through and discussed the data and collaboratively coded for specific key terms, such as 'GP', 'Emergency Department', 'accessing healthcare', and 'non-COVID symptoms'. Following this ongoing and iterative analysis was

Table 2. General practice clinics in Palmerston North.

Clinic No.	Website Available	COVID Website Message	COVID Phone Message	Location	Deprivation Score (low = Q1; high = Q5)	Enrolling New Patients	No. Doctors in Clinic
1	No	NA	No	Central	Q4	No	2
2	Yes	No	No	Awapuni	Q3	No	4 or 5
3	No	NA	No	Central	Q3	No	1
4	Yes	No	No	Central	Q3	Yes	(unknown)
5	Yes	Yes	Yes	West End	Q3	No	5
6	No	NA	No answer	Hokowhitū	Q1	No	1
7	No	NA	No	Central	Q3	No	2
8	Yes	Yes	No	Central	Q5	Yes	(unknown)
9	No	NA	No answer	Hokowhitū	Q3	No	1
10	Yes	No	Yes	Roslyn	Q5	No	15
11	Yes	Yes	No	Turitea	Q1	No	(unknown)
12	No	NA	No	Milson	Q4	No	1
13	No	NA	No	Central	Q4	No	1
14	No	NA	No	Awapuni	Q1	No	3
15	No	NA	No	Central	Q4	No	2
16	Yes	Yes	No	Central	Q5	No	9
17	No	NA	No	Central	Q3	No	2
18	Yes	No	No	Hokowhitū	Q2	No	2
19	No	NA	No	West End	Q3	No	1
20	Yes	No	No	Central	Q3	No	2

Note: Deprivation score is a measure of socio-economic level.

conducted and team discussion produced the final categories. The analysis focused on identifying key messages conveyed in the information about healthcare, with a focus on what was said, by whom and to whom.

Findings

The findings are presented in three sections, discussing in turn the healthcare messaging disseminated through Government sources, then through media sources, and then through general practices. Each section identifies the various approaches to communicating access to healthcare, and the importance of non-COVID-19 related healthcare practices.

Government messaging

Consistent COVID-19 messaging

The Government messaging during the COVID-19 Alert Level 4 lockdown focused primarily on the pandemic and appeared simple and consistent; the content of the messages was unambiguous, drawing on widely used tropes about Aotearoa New Zealand being 'our team of five million', which were memorable and, in the main, effective. The discourses of common good which underlined the various messages ('stay home, save lives') were highly visible and widely broadcasted. This form of messaging was included verbally in Post-Cabinet Press Conference Daily Briefings, online on the official Aotearoa Ministry of Health website and the COVID-19 pandemic website, in a pamphlet used in a nation-wide letterbox drop, and widely across traditional media, television, radio, and print media. Other distribution occurred through public health campaign messaging, making posters and advertising material available to businesses, and placed in public spaces, such as bus stops. Not surprisingly, there was considerable intertextuality of messaging, with related message tropes appearing frequently across all messaging forms and sites.

The messaging used in uncertain and evolving situations, such as the COVID-19 pandemic, will influence how people frame and understand how to behave. During these times, Governments rely on relationships of trust but are also dependent on people's exposure to the messaging and any alternative narratives that may be presented (Timotijevic 2020). However, not everyone is able to engage with what the messages represented, for instance, for people enduring disadvantages (e.g. poor health, poverty, insecure housing and work) before a disaster, coping during disasters can be more precarious (Blake 2020; Elers et al. 2021).

Inconsistent non-COVID-19 messaging

While the messaging emphasised COVID-19-related practices it contained very limited information about healthcare for non-COVID-19 related conditions. In fact, this messaging often worked to position medical buildings and services as places of risk for people with medical vulnerabilities. The dearth of information about non-COVID-19 care led to some public confusion and to people not seeking help for health concerns unrelated to COVID-19. This was noted by General Practice New Zealand, nine days after moving into Alert Level 4 (April 3 2020), when a press release indicated concern about 'national data

showing a steep decline in consultations over the last week' (General Practice New Zealand 2020). On the same day, the decrease in healthcare activity was also apparent in a news article that reported 'hospitals were now operating at around 50 per cent capacity' (Witton 2020). The Government was obviously aware of this trend and the healthcare implications, and during a Post-Cabinet Press Conference Daily Briefing soon after (April 6, 2020), Ashley Bloomfield, the Director-General of Health, articulated government concern, stating:

> … people who require health or medical care for other conditions not COVID-19 related … please do not delay seeking treatment for any condition. Please do not stop seeking care that you might need for any medical condition that you may have, whether it's a new acute condition or an exacerbation of an existing condition. (All-of-Government Press Conference 6 April 2020)

The message to seek healthcare if needed was reiterated again during a later Post-Cabinet Press Conference Daily Briefing (April 8, 2020) with Prime Minister Jacinda Ardern stating:

> Of course we have been telling people to stay at home, but if you are unwell, if you are symptomatic, if you've got a temperature, a dry cough, please call Healthline, or call your local GP, your iwi health provider, and do reach out for a test. (All-of-Government Press Conference 8 April 2020)

Although the Prime Minister was encouraging people to access healthcare, this messaging was subsumed within the description of symptoms relating to COVID-19, rather than related to more general health or non-COVID-19 health issues.

The official Government COVID-19 website also provided information about how to access healthcare. Yet, accessing this information required a two-step process; to locate this material it was necessary to look under a tab titled 'Individuals and Households' and then 'How to access healthcare' (New Zealand Government, 2020c). Once again any information on accessing general healthcare was overshadowed by 'whether or not you have COVID-19' and by the advice to 'phone first' so that risk of COVID-19 could be assessed (New Zealand Government, 2020c). This site did offer clear information about health facilities being essential and remaining open: 'health and medical facilities are recognised as an essential service and will remain open, even in Level 4 lockdown' (New Zealand Government, 2020c), but provided quite limited information around care for non-COVID-19 health conditions.

The tensions and confusions arising from positioning medical spaces as essential to care for ill people with COVID-19 alongside the advice to avoid physically presenting at hospitals or GP's may have contributed to a lack of clarity about non-COVID health issues. Although the various Government agencies and services did attempt to communicate the importance of addressing general health concerns, this was overshadowed by the strong, consistent messaging around COVID-19 behaviours. The brief messages about care for non-COVID-19 related issues were subsumed within the compelling and constant 'Stay home, save lives' messaging.

Media messaging

COVID-19 public health messaging generally saturated people with the rules surrounding each level of lockdown, such as restrictions on gatherings, requirement to legally work from home unless not possible, and accessing healthcare services by using

virtual, non-contact consultations where possible (New Zealand Government, 2020a). Very early on in Lockdown level 4, there was some messaging coming out on-line predominantly about how to access GP's and seeking help for non-COVID-19 issues. The next section explores the visibility and accessibility of these messages.

Clearer on-line messaging

In contrast to government messaging, on-line sources did provide considerable information about accessing healthcare across Aotearoa for non-COVID-19 health issues. For example, an online magazine article (27 March) written by a guest author who was a GP outlined 'how you can see your GP in lockdown in New Zealand. And what you can do to help us' (Hills 2020). This article included guidance on how to 'call your medical centre for advice' about illness and offered very detailed evidence about the importance and necessity of making appointments. The article also asserted that people should dial 111 in an emergency 'as you normally would' (Hills 2020). There was an imperative to avoid phone calls to GPs and instead to use internet-based services. The article stated, 'Do use internet services whenever possible to communicate and try to limit phone calls. We are having trouble contacting our patients while the mobile networks are overloaded.' This narrative produced a sense of urgency about the intense situation that the GPs were experiencing suggesting they were overwhelmed which conflicts with the other information encouraging people to seek help as normal.

In Palmerston North, during the Alert Level 4 lockdown, print production of the local newspaper, *the Manawatū Standard*, had ceased. Therefore, the principal source for accessing 'print' media was online, with reporting from *the Manawatū Standard* published on the *Stuff* media website. On April 3, an article on *Stuff* discussed preparedness levels for Palmerston North hospital should they have any COVID-19 cases and reported on the number of cases currently in the region. This article did relay the message to seek healthcare for non-COVID-19 related symptoms:

> If you have an exacerbation of an existing illness, reach out. If you are most unwell, call an ambulance. We don't want people suffering in their homes and thinking they can't get access. (Rankin 2020b)

Telling people to ask for help, not suffer with health symptoms, and generally encouraging people to seek professional advice seemed to be a core message in this text, and the narrative sought to direct and reassure people about still being able to access healthcare in Palmerston North during the pandemic. However, this message was located at the close of the internet-based article, which was primarily, and strongly, focused on COVID-19 issues.

Just two days later, on April 5, the *New Zealand Herald* posted an online article that included an extensive list of questions about what New Zealanders could and could not do during Level 4 lockdown. This included the question: *Can I visit the pharmacy, doctors, hospitals?* This was answered with:

> Yes, health facilities are also included in the essential business list along with hospitals, primary care clinics, medical laboratories, care facilities (e.g. rest homes). If people need to see doctor or other medical professional they must phone first. (NZ Herald 2020a)

While it is clear in this dialogue that healthcare is an essential 'business', the articles does not highlight that healthcare continued to be available for those with non-COVID-19 symptoms. The focus remained primarily on COVID-19.

Another *Manawatū Standard* news article on April 7 highlighted how GPs in the area were operating, and that measures had been put in place to handle the potential surge of COVID-19 patients. Like others, this article noted a 'sharp drop in people coming in with injuries from accidents', with one GP cited as stating that he was 'almost certain there would be a backlog of patients wanting help for conditions they were putting up with for now once the COVID alert level was relaxed' (Rankin 2020a). Given how quiet Palmerston North GP clinics reported their practices to be, the message here represented public tolerance and endurance for 'putting up' with non-COVID symptoms, and to call their regular healthcare provider to receive care and advice about being treated. In the same article, a healthcare executive commented that there had been a significant drop in people contacting general practices, which was understandable in the context, but she reassured people that all GP practices were open for business (Rankin 2020a). This messaging was useful, but it failed to specifically note that non-COVID-19 symptoms should not be ignored.

The commercial entity, nib Group health insurance, also placed information online regarding access to healthcare during the lockdown, with a fact list that included the question: 'Can I leave my house to seek medical attention during the lockdown period?' The printed response stated:

> If you require medical assistance, you should call your doctor, or the hospital, in the first instance and discuss your needs with them over the phone. (nib Group, 2020)

This messaging clearly outlined that medical assistance should be sought, and consultation with a doctor should be considered albeit over the phone. However, once again, specific comment about non-COVID-19 symptoms would have added more clarity to the message and reduced confusion about types of symptoms and healthcare seeking.

Given the vague or hard-to-find information the public received from official government sources and online media about healthcare for non-COVID symptoms and conditions, it is not surprising that the number of recorded GP visits drastically reduced in the first two weeks of Alert Level 4 lockdown. Further, the disseminated media message was still strongly influenced by the messages about COVID-19 promulgated by Government and health official messaging.

GP messaging

Next, we turn to general practices in Palmerston North to determine the types of messaging available to the public about non-COVID-related healthcare from these services. Nine of the clinics had an online presence through a website, but only four of those included messaging specifically tailored to the COVID-19 lockdown conditions, for an example, see Figure 1.

Inconsistent and unclear messaging

The four clinics with specific COVID-19 website messaging included information advising their move to using a telephone triaging system. These messages further requested

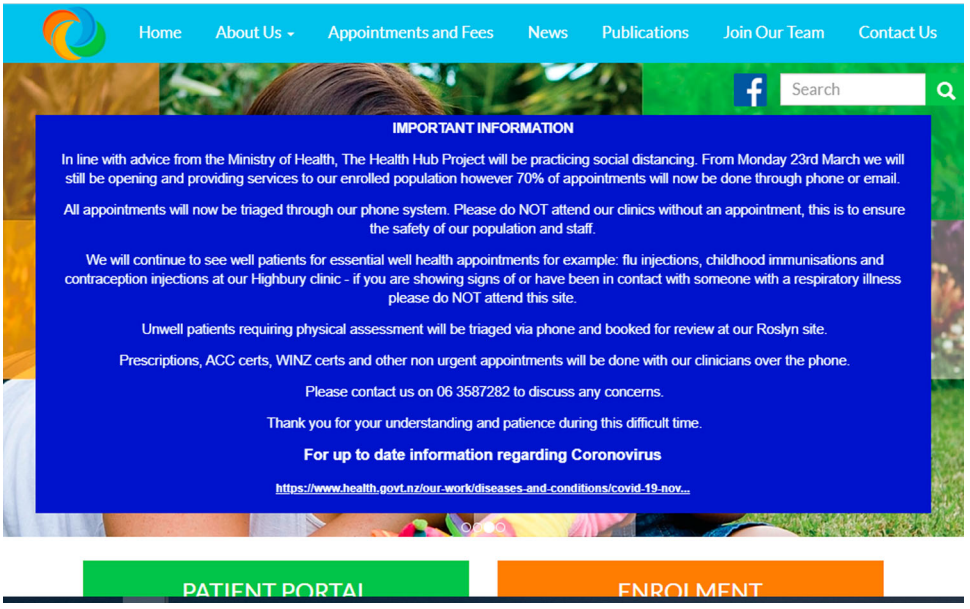

Figure 1. COVID-19 specific messaging from GP clinic in Palmerston North.

clients not attend the clinic in person, as phone consultations would be used for non-urgent health issues and to assess whether face-to-face health appointments, for such as flu vaccinations or immunisations, were necessary. Only one clinic website contained a message that specifically mentioned non-COVID-19 related health symptoms or illness. This message declared that the clinic was continuing to provide generic healthcare, stating:

> … are still providing healthcare … but in a different way, as we all know that even in this COVID-19 pandemic people are still going to get sick for other reasons. (Clinic 5)

Alongside this, the clinic provided a phone message that reiterated information about phone consultations now being standard and asking clients to call the clinic rather than attend in person, although this message foregrounded the pandemic. Only one other clinic presented a specifically tailored COVID-19 phone message. This message was focused on informing clients about what to do if they had flu-like symptoms or an inquiry about the coronavirus, but it also informed the caller that if their call was in regard to another matter (as opposed to COVID-19) they could hold the line and the call would be answered shortly. Of the 20 clinics located in Palmerston North, only two offered an after-hours telephone message that was specifically tailored to the unique COVID-19 lockdown conditions.

It was surprising that so few of the GP clinics in Palmerston North had an online presence, and that only a few of those with a presence attempted to use their website as a vehicle for communicating access to their services. Given the high percentage of New Zealanders online, the internet is now considered a major tool for communication (Fuchs 2020). Tian et al. (2009) note that 80% of internet users in the USA search for health information online. The other major communication channel for GP

clinics in this research, the telephone, did not have clear and up-to-date messages for people, particularly as those who do not have access to the internet are more likely to use the telephone as a means for gathering information and seeking healthcare support.

Discussion

Our findings demonstrate there was little messaging around accessing healthcare in Aotearoa New Zealand for *non*-COVID-19 related health concerns. Of the messages that were provided, most were unclear or vague, or they were subsumed by the prominent COVID-19 messaging. This was evident in all forms of communication at this time; government, on-line media and most concerningly, GP practices in Palmerston North. These messages primarily relied on access to the internet or telecommunications. It is likely that such access to healthcare messaging for non-COVID-19 health concerns further marginalised the communities that were disadvantaged and had vulnerabilities because of their limited access to internet-based resources. This is concerning as people with the most vulnerabilities were considered to be the most at risk (older adults, Māori, Pasikifa, and people with chronic health conditions and disabilities) and the 'stay home' message for was the strongest for them, with only limited messaging about how to seek healthcare for existing problems if needed. In a sense, they experienced compounded marginalisation in terms of healthcare access and health status (King et al. 2020).

The unclear and vague messaging may well have induced confusion about what actions to take in seeking healthcare. GPs were framed as essential services in official messaging, but this was counteracted by their concurrent positioning as risky places to visit, particularly for people with vulnerabilities to COVID-19 (older adults or immuno-compromised people). Escalating this, people were advised not to burden secondary services, such as hospitals, because they were being prepared to handle surge or large volumes of very ill COVID-19 patients. Contributing to any confusion was the inconsistent messaging across medical practices on what to do if their services were needed. Those GP services did have online or telephone messaging mostly focused that on COVID-19 symptoms.

Given that Palmerston North and the surrounding area had the lowest rate of PHO registrations, with the lowest number of PHO-registered Māori and Pasifika in Aotearoa (Ministry of Health 2020), it is possible that a number of people in this area would not even be registered with a GP. For these communities, it may be even less clear what they should do when they need a primary healthcare service, like a GP. This also provides a timely reminder that disaster and health messaging should be inclusive of the diversity within communities so as not to perpetuate further disadvantage and harm (Blake 2020). This is even more salient when it is recognised that Aotearoa New Zealand has a long history of systemic racism in its healthcare practices (Houkamau et al. 2017; Reid et al. 2019). There also need to be strategies around how disadvantaged groups can access information if they do not have access to, or do not engage with, technology and are at risk of not receiving critical health messaging during a pandemic.

It is also important to consider how this health messaging may be an effect of the neoliberal practices that shape our healthcare systems. The COVID-19 lockdown led GP

services to become less financially viable because of a reduction in patients and the increased cost of preparing for the virus (requiring PPE, perspex barriers, etc.) (Henry 2020; Martin 2020; Whyte 2020; NZ Herald 2020b). This loss of revenue could conceivably be an underlying driver for the change in messaging across the period; once the reduction in people seeking healthcare services became clear, healthcare messaging increasingly communicated that GP services were available by teleconference consultations or direct contact if that was essential.

Health messaging is important during ordinary times and more so during extraordinary events, such as a pandemic that utilises 'lockdown' measures to reduce and control community transmission (Hyer and Covello 2005). This research has clearly shown that health messaging for non-pandemic related health issues was not considered initially in Lockdown level 4 and then when mentioned the messaging was rendered almost invisible to COVID-19 messaging. GP practices did not have clear messaging for their patients either on-line or in telephone communications initially. While Aotearoa is often held up as a case of successful management of COVID-19, this research has also highlighted, that there are still lessons to be learned to ensure that health communication does not further disadvantage marginalised communities.

Conclusion

It is well known that the content of messages and how they are communicated during disasters, such as a pandemic, will impact on how people respond and react. With the onset of COVID-19 in Aotearoa New Zealand, and the subsequent Level 4 lockdown, both the provision of, and access to, primary healthcare services proved challenging. Public cooperation during this time was essential to minimising the spread of the virus (Bannor et al. 2017; King et al. 2018), but this required clear communication about health risks and safe practices, particularly when the well-being of the nation was reliant on clear directives and advice from government and health officials (Kahan et al. 2003; King et al. 2018). While it is argued that effective risk communication can be measured by 'behavioural compliance' (Fish et al. 2017), this overlooks those who do not easily fit the criteria. It would appear that the success in 'flattening the curve' in Aotearoa New Zealand has demonstrated 'compliance' with the demands of Alert Level 4 (Fifield 2020), implying that messaging around minimising the spread of the virus has been effective. However, this does not consider any increase in morbidity and mortality for other health conditions because people delayed or did not access healthcare for non-COVID-19 health conditions, a concern that GPs have themselves expressed (Henry 2020; Martin 2020; Whyte 2020).

This study argues that public health messaging during a disaster for general health concerns should be given appropriate attention so that messaging is clear, concise and consistent, especially when it comes to consulting healthcare professionals like GPs. We would also recommend that the Aotearoa New Zealand Ministry of Health produce templates to ensure consistent messaging and provide support to GPs to establish effective websites and telecommunication practices. Resources should also be given to avenues of communication for those who are unable to access the internet. Additionally, we recommend that any avenues of communication should be diverse and inclusive so that all groups in society, including Pasifika and Māori who are often overlooked, are

supported for their collective wellbeing. This includes developing genuine relationships based on reciprocity and care. Access to healthcare is necessary in both the everyday and in extraordinary times.

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