

Good morning,

Thank you for the opportunity to submit my thoughts regarding the latest DCNZ proposal. I am an orthodontist and so my third point relates more specifically to multi-chair clinics and seeing younger patients, which is a majority part of our patient base. I have a few concerns:

1. I do not believe it is scientifically valid to base risk assessments on vaccination status. It is well known that a vaccinated individual can still transmit the virus; so there is a risk of transmission amongst both vaccinated AND unvaccinated individuals. Even if the risk of transmission may be lower in vaccinated individuals, transmission is still a risk. In fact it is probable that vaccinated individuals are more likely to be asymptomatic and therefore are more likely to unknowingly come into an appointment and potentially transmit the virus. Unvaccinated individuals are more likely to be symptomatic and therefore are more likely to stay away and not attend an appointment. Thus, a more logically tenable argument is that the vaccinated individual presents MORE risk in this case.

This point is supported by the updated MOH position statement (dated 25th November) where it states "...for health care workers, the risk of seeing a patient with asymptomatic infection is the more important issue, rather than the vaccination status of the patient." <https://www.health.govt.nz/system/files/documents/pages/ministry-health-position-statement-management-unvaccinated-individuals-healthcare-settings-25nov21.pdf>

2. Universal precautions. Following from my point above, it makes more sense to me to have universal precautions for all our patients - to treat all patients as 'medium' risk. This is regarding PPE requirements - I have thoughts on fallow times outlined in my last point below. I believe standard use of N95 masks (4 hour sessions as per the DCNZ proposal) would offer the best protection for us and our patients. Universal precautions have served our profession so well over the years; to treat each patient equally with stringent care and cross infection control. Of course, we do need to screen for Covid risk factors (symptoms, places of interest, if they have had contact with symptomatic people, awaiting a Covid test result etc) but I propose a different function for this screening. It could be used instead to reschedule a patient who is symptomatic for non-urgent appointments, and then have a 'high risk' category for patients who have to be seen urgently for an emergency. These 'high risk' patients would require additional PPE similar to those used in Level 3. This distinction is not based on vaccination status, but rather on symptoms and other factors picked up with the screening questions. I do not believe that there is scientific justification to class any patient as 'low risk' as per my point above.

3. Fallow times. It does not make any sense to me as to why under 12s who cannot yet be vaccinated to have no fallow time in multi chair clinics, but anyone over 12 (in orthodontic settings, many of our patients are in the 13-18 age group) who are also unvaccinated require fallow time. It does not make any scientific sense that the protocols for an unvaccinated 12 year old regarding fallow times would be so vastly different to an unvaccinated 13 year old. I fully understand and accept that it is a sensible and pragmatic measure to have a general 'slow down' of our schedules to have adequate time to wipe down and carefully go through the disinfection protocols between patients, but if a room is adequately ventilated (HEPA filtration, natural ventilation with open windows etc), is the notion of fallow times evidence based? The guidelines under Level 3 were based on AGP; I could understand these. But for simple non-AGP orthodontic adjustments that take 5-10 min, with the appropriate PPE worn, with plenty of time before the next patient to disinfect and follow cross-infection control protocols, I do not understand why fallow times are needed. This appears to me to

be especially illogical if this additional requirement is only for unvaccinated individuals when vaccinated individuals also carry a risk of transmission as outlined in point 1 above.

Thank you for taking the time to consider my submission.

Kind regards
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Summary

- Individuals cannot be refused access to health care. Restrictions to access to health care must be informed by a risk assessment, and the onus is upon the provider to justify that the risks are sufficiently high to support those restrictions.
- Total vaccination coverage and the prevalence of COVID-19 in the community are important factors in the efficacy of any mitigations aimed to prevent transmission.
- Other public health measures in place also contribute to reducing the risk.
- Vaccination status is one of many risk factors for infection and transmission. Unvaccinated patients who contract COVID-19 pose a high risk to themselves and to others. However, there is no evidence that the routine application of an approach incorporating pre consultation testing is justified.
- Individual patients have a responsibility to follow Health and Safety guidelines and procedures when utilizing a health service.
- Pathways exist for decreasing the risk of transmission from any asymptomatic individual. These pathways should be utilised effectively prior to the introduction of additional interventions such as pre-consultation testing.
- Children form a large group of individuals who are unable to vaccinated and as such are likely to form a majority the group managed through an alternative pathway. Specific consideration must be given to how this would impact on children's clinical care.

Testing unvaccinated people prior to health care

Testing as a screening tool vs targeted testing

Testing of individuals for COVID-19 can provide a high degree of reassurance that an individual does not have active infection. However, for health care workers, the risk of seeing a patient with asymptomatic infection is the more important issue, rather than the vaccination status of the patient. Vaccination significantly reduces the risk of developing severe infection and whilst vaccinated patients are much less likely to transmit the virus, transmission is still possible. This emphasises the need to focus on strong public health measures and vigilance for asymptomatic spread in the community based on thorough basic public health measures rather than on patient vaccination status alone (noting that vaccinated health care staff further reduces any risk).