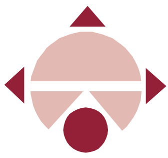

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2022 Infection Prevention & Control for General Practice

April e newspage # 3 – Are your Infection Prevention & Control actions aligning with current knowledge?

Before loosening any of your preventative measures in your clinic, there are some eyewatering facts as April comes to an end

1. We have no idea how many people are infected in any state because not everyone is testing who has symptoms nor is population surveillance really occurring, but you could probably multiply x 5 – 10 to get Victoria's total today. It follows that we don't know the mortality rate (deaths will peak two weeks after Easter) or how hospital admissions might change in 2 weeks and if this will impact on elective surgery. The test, trace model was what opening up was built on! *Note that WHO advises a case positivity rate below 5% to show you are doing enough testing - ours is currently 16- 20% which tells you that nowhere near enough testing is happening.*

2. While the newer vaccines this year will be pivoted towards later variants and with some being intranasal, how good will uptake be if we can't even convince a third of our eligible community to get triple vaxxed now?

3. Herd immunity will not occur unless the virus runs out of susceptible persons to infect. If we are not immunising under 5's and immunity, both natural and artificial is short term, then the virus is not likely to run out of people to infect and will continue to impact on the healthcare system and the economy.

4. Current transmission rates are extremely high and although expected to plateau, it is at too high a rate - this is not a little cold that kills 30-50 per day and hospitalises 3,000 – and expected to rise 2 weeks after Easter.

5. Are people dying with or of COVID? A lot of care is taken on a death certificate to establish the cause of death – if a person's life has been shortened because of COVID, I think you know what the answer is.

6. This is a pandemic infection and cannot become endemic really – hardly in the same category as malaria

7. Omicron is many, many times more infectious than the ancestral strain and as pathogenic. If not for the vaccine the health system would have crumbled. Even so, more have died in this first quarter than in 2020 and 2021

8. The vaccine (now not mandated) and a requirement to stay home for 7 days when infected are public health measures. However, apart from some groups, a person must pay for a RAT. There is no public health mandate for buildings to provide 6-8 changes or air per hour and mask wearing is only required in vulnerable settings.

9. Measures we are asked to take personal responsibility for are – daily RATS when a close contact, mask wearing indoors, hand hygiene, cleaning, buying RATS and reporting positive results, ventilation.

10. The continued high circulation means the risk of a variant emerging is higher – no prediction that it will be milder or vaccine susceptible

The accumulating data for long COVID shows 20% are affected – this has its own cost on both health and the economy. I advise all who work in healthcare to wear P2 respirator masks indoors at all times at work and ensure your building provides sufficient air changes. Rather than rely only on testing, I would act as though infectious so I can protect others. And if P2 respirator mask wearing was mandated for two weeks in public indoor venues, the rate of infection would drop quickly rather than slow plateauing in front of us. Not lockdowns, just masks when numbers are so high.

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