NZ Dental & Oral Health Therapists
Nga Kaihaumanu Hauora a-Niho, a-Waha hoki

26 May 2016

Marie Warner
Dental Council
PO Box 10-448
Wellington 6143
New Zealand

Dear Marie,

Oral Health Scope Consultation

We are pleased to be providing this submission in respect of the Oral health therapy scope of practice consultation.

Your consultation documents were first issued on 31 March 2016 and we have taken the opportunity to review and consult with our membership and industry stakeholders regarding it. You will be aware that we made a submission during the 2015 consultation period where we indicated our strong preference for the scope and designation Oral Health Practitioner.

We have been very pleased to have participated in a number of consultations with the Dental Council over recent months and feel that the issues we previously raised have been satisfactorily clarified. Our members have had the opportunity via Webinar and face to face meetings (Christchurch, Wellington & Auckland) to participate and consult directly with the Dental Council and we would like to thank you for this the dialogue.

While our members have the opportunity to make their own submissions, NZDOHTA would like to confirm our views:

Firstly, to applaud the Council for introducing the new Oral Health Therapy scope of practice that was long overdue. We would also like to suggest that any future oral health programmes gazetted through universities undergo prior approval from the Dental Council to avoid creation of a qualification that does not have a matching scope.

Our responses to the specific questions are:

Q1. We would like to seek clarification on the stance of Auckland University of Technology on its graduates to practice on patients 18 years and over. The current consultation document suggests that BOH graduates from Otago University are not adequately trained but does not clarify AUT's position.

Otago University states "complex carious lesions for all ages" is the concern for its BOH graduates. However, dental therapists and the soon to be oral health therapists are currently diagnosing complex carious lesions. The tooth 36 with a P5 lesion in a 12-year-old requires the same degree of complexity to diagnose as a P5 lesion in an 18 year old and as with a 25 year old.

New Zealand Dental and Oral Health Therapists' Association
PO Box 9893
Marion Square, Wellington 6141
Phone: +64 4 473 9547
E-Mail: contact@nzoral.org.nz Web: www.nzoral.org.nz

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We would also like to seek further clarification on the scientific basis of choosing the age of eighteen as the end point for practice. Is there any significant dentine or enamel change, that is obvious or that requires different management techniques between the ages of 18 years to that of a patient that is 18 years and 1 month old?

Is this then a number based on the current Ministry of Health funding agreement. If yes, should the scope be based on funding agreement or the needs of the population?

The average median income for 18-24 year olds is considerably lower than that of 24 years and older according to the 2013 national census. Considering the 18-24 year olds are either at universities or in lower paid jobs; it would be more pragmatic to consider the needs of this population group.

Q2. We strongly agree that a constructive professional relationship between oral health therapists and any other oral health professional is essential to maintain collegiality and it also supports peer learning. A written agreement is not required and the Council should consider the same arrangement for dental therapists scopes in future.

Q3. Yes we strongly support the move from direct clinical supervision to consultative agreement.

Q4. We agree with the current proposal and agree that oral health therapists may choose to limit their scopes of practice without the need to register as a orthodontic auxiliary since it is already part of their training program.

Q5. We agree with the competency standards and support a credible process of maintaining professional standards to keep the profession, the practitioner and the public safe.

Q6. We agree with the proposed registration process and would like the Council to consider a consumer engagement and information sessions aimed at informing the public and the potential employers of this change. While the Council is in our view not mandated to be concerned about employment relations; the current workforce is largely employed by district health boards and their multi-employer collective agreements (MECA) or single employer collective agreements (SECA) do not have the provisions for employment of OHT's or a relevant salary scale. We would like the Council to formally advise Public Service Association(PSA), APEX Union and the DHB's of this change and then they can progress with their own processes to facilitate the future needs of this emerging workforce.

Once again thank you for the opportunity of presenting this submission.

Jennifer Pelvin

For NZDOHTA