[redacted]

Page 2: Your demographics

Q1 Your details

Name	**Katy McLaughlin**
City/town	[redacted]
Email	[redacted]

Q2 Your submission is in the capacity as — **dentist or dental specialist**

Page 3: The proposal

Q3 Do you agree or disagree with the proposal to remove the 18-year age limit for restorative activities from the OHT scope of practice including: accredited, gazetted programmes allowing oral health therapists to perform restorative treatment on patients 18 years and older an exclusion, such as "Restorative treatment on patients 18 years and older", being placed on oral health therapists' scopes of practice until they complete an accredited adult restorative programme which will allow them to apply to have the exclusion removed (noting that the activities registered oral health therapists can currently perform within their scope of practice remain unchanged). — **Strongly disagree**

Page 4: Your support

Q4 Please describe why you support the proposal — **Respondent skipped this question**

Page 5: Your concerns

Q5 Please describe your specific concern/s with the proposal

I have many concerns regarding the proposed changes. I believe there are fundamental practical and ethical limitations in how this concept has been presented.

Most alarmingly, there is a paradoxical approach to treating a 'broader group' of patients and I would be grateful if Council could define this 'broader group'. My own interpretation is of a high-needs or high-risk group with limited access to funding, and the proposed changes in targeting this group indicate that the higher the need for care, the less formal education and regulation required by the health professional. This is not how we should treat some of our most vulnerable members of society.

This effectively promotes a two-tiered system of care based on cost, and I ask Council, who will choose to seek this treatment when given equal opportunity and equal access to a dentist or oral health therapist? The reality is, this proposal seeks to increase access to oral health therapists, while decreasing access to choice. It doesn't seem fair to remove the choice for a specific group of people based on the ability to pay for treatment.

In defining a 'broader group' of patients, it is also important to remember that our own community has its own unique needs that cannot be considered equivalent to other 'benchmark' nations and systems. Using a 'benchmark' in Australia does not reflect on the success of these changes to community oral health, and this cannot be directly applied to New Zealand and our own environment and population. We cannot ignore our own circumstances and take on the policy and initiatives of other countries, particularly without strong supporting evidence of a real effect in improving oral health.

I strongly agree that we, as a profession, urgently need to support initiatives to provide appropriate care to those in need and to improve access for all New Zealanders. Improving access to healthcare should be about reducing inequalities, not defining them further. We have qualified practitioners who are able to place restorations for adults (BDS). I strongly believe we should be working on ways to use our existing workforce appropriately rather than spending additional time and money manipulating a new workforce that is driven and dictated primarily by cost. This undervalues both the existing role of our oral health therapists and the role of our dentists. If prevention programmes with oral health therapists were more accessible, we would not be debating the need for oral health therapists to place restorations.

In addition, this has the potential to increase the perceived tension that has long existed between the public and the profession regarding the cost of dental treatment and supports the notion that charging for care is not justified when equivalent care can be provided at a significantly reduced cost.

From a practical perspective, creating a new course and training programme for a defined 'size' restoration is absurd. Any health care professional will advise that treatment is provided to a patient, not to a hole. Any dentist will also tell you that occasionally a hole is deeper or more complex that it may seem at first glance. The risk for needing to seek assistance or act outside of scope seems unjustifiably high when a restoration for an adult can be completed by a dentist as part of overall care.

Page 6: Details about OHT scope, qualifications and competencies

Q6 Do you have any specific feedback on the proposed amendments to the OHT scope of practice, prescribed qualifications or competencies as set out in appendices 1 & 2?

No

Page 7: Specific comments on the proposal

Q7 Please provide us specific comments related to the OHT scope, qualifications and competencies.

Respondent skipped this question

Page 8: Anything else

Q8 Do you have any further comments on the proposal?	**No**

Page 10: Last thoughts

Q9 Please provide us your feedback	**Respondent skipped this question**