Page 2: Your demographics

Q1 Your details

Name	**John McCabe**
Company/organisation	
City/town	
Email	

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

We already have professionals trained to perform these tasks. They have a degree called a BDS which takes 5 years minimum. In some countries an under graduate degree is also becoming a pre requisite.
Since Oral Health Therapists have been trained to treat high school students in New Zealand there has been no study to follow up the success or otherwise of the restorations they have placed. As patients get older, generally the cavities get deeper . Endodontic involvement is inevitable in many cases. Where will this be incorporated into a three year training programme?

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?	**Yes**

Page 10: Last thoughts

Q9 Please provide us your feedback

with prevention to a small extent. These people can already access hygienist treatment for relatively cheap. It hasn't caused a flood of patients to get cleaning and fissure sealants. Low income patients tend to be reactive, not proactive, due to the reality of their financial existence. Even at 40 dollars for an extraction, many struggle to find this money, and therefore will not show up after making an appointment for pain, due to it not being sore anymore. These people live week to week, and without pain, dental problems are the bottom of the list. (We need serious investment in public health education to change this, not fiddling with who provides the care). We need to rememeber that despite free dental care for under 18s in Christchurch; there is still an appallingly low takeup of the OHSA contract treatment in adolescents. Many show up in a panic at age 17 (and 30 days) Another is medical complications. Of the new patients seen at our private clinic this week, over 80 percent needed extended consultation in regard to such things as; Failed complex previous treatment; serious medical conditions including cancer, jaw xrays for complex treatment planning required, counselling around failed previous treatment at previous clinics. Treatment planning can look simple, until you have the full knowledge of what options are available. If all you have is a hammer, everything looks like a nail. There is not one patient I have seen this week thus far that would have been fully informed of treatment options had they not been seen by a dentist with the appropriate indepth training. The answer to whether to save teeth and what is appropriate in those situations needs full consent prior to treatment, and in order to give that consent, the operator doing consent must have a full understanding of each procedure. The implications for treating medically compromised people who you do not identify as medically compromised can be serious. I strongly believe it takes a very solid scientific and medical background in a 5 year minimum dental degree to provide that base of knowledge to ethically provide treatment planning advice to patients. The treatment of children under 13 has always been relatively straightforward in regard to treatment options. Morbidity tends to increase through life, as does dental treatment complexities. Where more complex treatment planning has been required, it has often been referred out of the school dental service for good reason. I strongly believe that Oral Health Therapists and Hygienists have a huge amount to offer the public, and dental community, but not seperated from the dental team. I also believe that adult scope if adopted should be an additional formal qualification on top of the 3 year program already offered. We already have to squeeze in a lot to fulfil the training in hygiene, and children's dentistry. It defies belief that we can deliver better outcomes for the public by dropping parts of an Oral Health Therapists Training, to add in additional adult scope training. Hygienists already play a major role in reducing the cost of preventative treatment of cleaning and advice (and already are able to fulfil that role in all age groups with current models of registration). I believe that if it is deemed necessary to provide more ability to do simple fillings at a low cost then Oral Health Therapist may be capable of fulfilling that role, but as part of a team. (Not working isolated in their own clinics). It is my belief that Oral Health Therapists, Hygienists, and Orthodontic Auxillaries were formulated as part of teams to help meet the dental needs of the population, and help to keep the cost down, especially in the public health system. (The origin of Dental Therapy). But this has always been in structured environments in dental therapy, working as part of a team lead by a dentist. Even in the District Health Boards, where there may not be a dentist on site; there is always one in a structured relationship, only a phone call away for advice and support. For example, what happens when a low income patient pays their examination fee to a therapist in solo practice, and then finds out their high needs dentition (most of them) actually needs a dentist to treatment plan. Does that low income patient then spend extra money to go get more advice from a dentist? This will only act to undermine the confidence of patients in the dental industry further than it already seems to have sunk. We already hear about frustrated parents having the run around for work outside therapist scope in the Community Dental Service. I work with incredibly talented and hard working Oral Health Therapists in my various roles. It is dissapointing that this debate seems to be one of divisiveness, and the need for one side to paint the other as “defending turf from greed”. Or on the flip side, for the argument from the other side to be one of dangers of incompetent treatment or diagnosis. Both Dentists and Oral Health Therapists have a set of skills that have been developed to be used in team environments. If the age restriction is removed from Oral Health Therapy, I would still like to see it being as part of a structured team relationship where the public can look forward to positive outcomes. At the moment I think the debate could best be described as parties looking for best outcomes for there focus group. I can see the positive outcomes for Universities having more students. I can see positive outcomes for Oral Health Therapists having increased enjoyment of work, and increased income in the private sector. On the flip side if the proposal is unsuccessful I see the positive outcomes for Dentists who are concerned about their job from a workforce standpoint (unemployed young dentists). But the job of the Dental Council should be to safeguard better health outcomes to the public. The concern of removing Oral Health Therapists from the dental team is that those positive outcomes for the general public will be jeopardised in favour of political expedience and interest groups. The world is changing, and we need a workforce that reflects the needs of the growing inequality of New Zealand. Oral Health Therapists have a huge part to play in that workforce. But removing the person who has the entire picture (the Dentist), does not lead to positive outcomes for patients. I strongly recommend if the Oral Health Therapy changes are to go ahead, then it must be into a team environment