[redacted]

Page 2: Your demographics

Q1 Your details

Name	**Gwen Smart**
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

The amendments proposed are simple, but do not reflect the complexity of existing problems, nor anticipate issues that would arise if the proposal is confirmed.

There is a high level of unmet need in the <18 population under the current system: thousands of children are missing regular oral health care and education. The oral health therapy workforce is already under stress, is ageing, and especially in rural areas, attracting and maintaining a stable and sufficient workforce is already a challenge. Removing the restorative age limit from the oral health therapy scope of practice would provide incentives to work on the adult population in a private context, at the expense of the COHS and the provision of care to the vulnerable <18 population.

Public confusion already exists with regard to the differing scopes of oral health therapists and dentists. The proposed changes would likely compound this confusion. Patients may have difficulty knowing 'where to go', and who can provide what services. Socioeconomically disadvantaged patients will likely present to the perceived 'cheaper option' when this may not be appropriate to their treatment needs, wasting both patients' and providers' resources, and especially in emergency situations, increasing the risk of adverse oral and general health outcomes for the patient. This may also act to damage public perception of both oral health therapists and dentists.

Oral health therapists are well trained to manage some of our most difficult patients - young children and adolescents. This is where their strength lies. While the teeth of an under-, and an over-eighteen year old may be the same, generally speaking, children and adults (especially those with extensive needs, complex medical or social histories, and the growing number of dentate but heavily restored elderly) pose different challenges.

To adequately inform patients of their treatment needs in order for them to make informed decisions regarding their care, oral health therapists would have to to identify and present all treatment needs and options (despite not being able to provide some of these). To be able to do this would require at least the full theoretical and diagnostic, if not the technical components of the BDS course to be taught. It seems unreasonable that this could be taught in a short course.There is insufficient detail on what the adult restorative programme would entail.

Even with a certified adult restorative programme, it is likely that the degree of support required to manage these more complex patients would go beyond the existing consultative professional relationship between the oral health therapist and the dentist.

If less costly restorative work can be provided by oral health therapists, adult patients with other treatment needs will likely present to a number of different providers (dentists and oral health therapists). This will have negative impacts for the patient through loss of continuity of care, and for practitioners; where treatment planning and provision is divided, complex issues of professional accountability may result, especially if the development of a collaborative document is not mandatory.

It is unclear from the proposal document how removing the restorative age restriction would improve accessibility to quality oral health care for New Zealanders.

Without firm evidence for the benefits of such a system, a "trend" in other oral healthcare systems does not justify this change.

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

While I strongly disagree with the current proposal, I think there are ways in which its general idea and aims could be maintained while limiting the risk of negative impacts for patient and profession. For example: A full initial examination could be provided by a dentist, including comprehensive discussion regarding treatment needs, treatment options (risks, benefits, finances etc.) and the services through which these could be accessed (dentist/ OHT). Patients with appropriate treatment needs (straight forward general medical history, limited direct restorative work only, no local complications such as complex occlusal or other local factors and suitable ability to manage the treatment needed) could consent to a course of treatment provided by an oral health therapist. This would require: A formal referral from the dentist The oral health therapist to have appropriate or additional training The dentist to be available for consultation and support regarding the patient's care The referring dentist to be available to provide any treatments outside the oral health therapy scope of practice that become necessary during the course of treatment ? oral health therapy costs for adult patients being standardised, possibly with govt. subsidy. If a patient qualifies for this care pathway, possibly some form of reimbursement (partial) on the initial consultation, to a standard fee Once one course of treatment provided - subsequent courses of treatment/ recalls would require re-referral from a dentist Each practitioner would retain responsibility for the care they have provided This could address some of the concerns raised regarding the complexity of care necessary, relative to the level of training completed. It would strengthen the practical and professional relationship between dentists and oral health therapists, while maintaining good continuity of treatment, and could improve access to care, particularly to those faced with financial barriers but with limited treatment needs. By improving access to oral healthcare for such patients at this earlier stage, with minimal intervention and preventive methods, more patients with more complex treatment plans could be managed by dentists, and the burden of patients with more extensive needs would be reduced in the long term. The example suggested here does not, however, deal with the significant issue of unmet need in our under 18 population and would likely still disincentivise oral health therapists from working in this area. As the Council recognises in the proposal document, "improving oral healthcare access and outcomes for the public of New Zealand is complex and requires a multi-faceted approach". However, without addressing the many concerns raised, there seems to be a great deal of uncertainty as to whether the proposed changes to the oral health therapy scope of practice would indeed be a "positive step". Identifying and addressing social, psychological, cultural and economic barriers to accessing care, promoting oral health education and disease prevention, strengthening collaboration and mutual support between groups of oral healthcare providers, and establishing a system of wider (if not global) accessibility to publicly funded or subsidised care should be the priority.