[redacted]

Page 2: Your demographics

Q1 Your details

Name	**Megan Martin**
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

1. Complexity of dental care
Comprehensive restorative care is not simply filling teeth that are decayed, and offering advice on prevention of disease. Consideration of the entire body as well as entire mouth is needed. Some adults have very complicated medical issues requiring knowledge on their management for safe treatment. Some medical conditions can also exacerbate oral health conditions. A comprehensive knowledge of both oral and general health is required to provide the best and safest treatment. I do not believe a 3 year training period can cover this with adequate depth to provide comprehensive management.
2. Adequate consent
In order to meet the rights of a patient to informed consent, a practitioner needs to be able to provide the appropriate advice for dental treatment options. How can a practitioner attain the adequate consent for treatment if they do not discuss the full extent of treatment options? Is it appropriate to continually fill a heavily filled or broken down tooth when a crown may be a better choice? A practitioner also needs to consider the occlusion and the whole mouth when considering treatment for each individual tooth. The current qualifications and training provided through a BDS encompasses these considerations. I do not believe a 3 year training period can cover the knowledge required to provide the adequate level discussion for treatment options. I believe everyone has the right to receive the same level of care from the same level of qualified professional no matter their socio-economic background.
3. Public confusion?
It is unclear if the therapist will be able to be directly accessed by the public or if they will be working directly with a dentist to perform dentist prescribed treatments.
I am concerned that direct access will only confuse the public about who they can see. Restorative procedures and preventive therapy for dental caries and periodontal disease cannot be offered for relief of pain, which requires endodontic or surgical intervention. I believe it will be confusing for the public to decide who they can see for their concerns to be addressed. If direct access is allowed, who will be available to carry out pulpal treatment should there be a pulp exposure during treatment? Under the recommended changes, therapists are not permitted to provide pulpal treatment on permanent dentition.
4. Improving access?
It is suggested that having oral health therapists able to provide restorative and preventive care will improve access for those who are currently unable to. I assume this is inferring that dental treatment will be cheaper when provided by Oral Health Therapists. The base costs for dentistry are expensive. The materials, equipment, sterilisation processes are standard costs which cannot be decreased by changing the workforce. I personally have experience working in both a DHB setting and a primary health organisation and can report that those with unmet dental need who seek these services are predominantly those in pain requiring surgical or endodontic intervention. It appears that providing additional restorative practitioners will not aid this problem at this stage. In my opinion, subsidising dental costs for those who are in greatest need and not in a financial position to access care, is a far better model for improving access for critical dental care.
5. Working relationship with the dentist.
The oral health therapists still require a working relationship with a dentist and in the words of the proposed changes document, “Practitioners within the consultative professional relationship are jointly responsible and accountable for the standard of decisions and care delivered to patients based on professional advice sought and given”. The cost of having dental “supervision” would minimise any ‘cost saving’ of having an additional workforce. If the dentist becomes responsible for the work, would it not be advisable that the dentist perform the work?
6. Workforce dilution
There is currently a huge unmet dental need in many children. Children are presenting for emergency treatment due to untreated dental decay with pain and infection. A total of 7,470 children needed to have a General Anaesthetic to have extensive dental treatment in just 1 year in 2014(1). This clearly exemplifies the unmet need of the children in our country. Extending the scope of practice for the profession allocated to treating these children, can only have a negative impact on access and treatment of these vulnerable members of society.

References
1. Hunt, G.R, Foster Page, L.A & Thomson, W.M. (2018). Dental treatment of children under general anaesthesia in District Health Boards in New Zealand. New Zealand Dental Journal, 114(December), 155-163

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**