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10 April 2019

Dental Council Consultation on the age limit for restorative activities in the oral health therapy scope of practice

Submission: **New Zealand Dental Association**

Submitter: **David Crum (Chief Executive)**

Q1. 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**

1.1 The Association understands and agrees accredited, gazetted programmes are required for registration in all scopes of practice and that all who are registered in scopes of practice are required to have successfully completed the accredited, gazetted training programme.

- **an exclusion, 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). If you disagree, please detail why.**

1.2 An exclusion, 'Restorative treatment on patients 18 years and older', should be placed on oral health therapists' scopes of practice until they complete an accredited adult restorative programme.

However, under the arrangement currently proposed in the discussion document, the New Zealand Dental Association (NZDA) for the following reasons, does not agree with the removal of the age limit for restorative activities for the oral health therapist (OHT) scope of practice.

Reasons:

1. One of the stated purposes of the Dental Council's proposal is the removal of inconsistency between the dental therapy (adult scope) and oral health therapy scopes.
   Given that statement and intent, it is our view that it is entirely appropriate for the Council to also duplicate the requirement for an OHT (as is the case with dental therapists -adult scope) to practise their adult scope under direct supervision or clinical guidance of a dentist, or dental specialist.

This requirement needs to be added into the scope of practice for OHT's, as it relates to the extended practise of dentistry on adults. This is to ensure the provision of treatment to adults under this scope is safe and effective. Direct clinical supervision or clinical guidance are key factors in ensuring patient safety.
This need for a dentist to be involved is particularly important with respect to diagnosis, treatment planning and informed consent (see later). The consideration of this extension should be far greater than just that of the clinical activity of preparing decayed teeth and placing simple direct restorations.
To uphold patient rights and for the safety of patients it is our position that these 'age' extended restorative activities be performed under prescription of a dentist (see later).

2. The Association does not support a move to allow OHT's to provide restorative treatment to adult patients independently, on the basis that provision of comprehensive diagnosis and treatment planning is a prerequisite for the ability to obtain genuine informed consent. Patients have rights and foremost among them is informed consent. A real informed consent discussion requires the provider to have far more extensive knowledge regarding treatment modalities and potential outcomes, than those learned in the limited scope of oral health therapy.
   Adults typically present with a considerably more extensive and varied restorative treatment history and accumulated disease process than the age group OHT's currently provide restorative care to. With adult patients much of the initial consultation following diagnosis is around treatment options and particularly priority, process and risk / benefit discussions relating to clinical procedures OHT's are not trained to provide. In our view to adequately hold such discussions in the patient's best interests, the knowledge, training and expertise of a dentist is required.

3. Further to the last two points, it is our understanding that the extended scope course being developed at the University of Otago will prepare OHT's to treat adults within the current scope under the prescription of a dentist. Hence it is our view that such prescription and supervision should be included into the extended age restorative scope.

4. For reasons of developing sound team interactions, it is our preference that OHT's undertaking this training do so in an environment where dental students are also training, and a combined training environment should be considered as desirable and even a prerequisite for course accreditation.

5. We propose the scope not be amended in the format described in the consultation document and we suggest an alternative (see answer to question 2, OHT scope of practice).

Q2. 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?

2.1 OHT scope of practice

The Association believes it is unacceptable for the changes proposed to, by default, result in the removal of the requirement for direct supervision or clinical guidance, for oral health therapists providing adult care. Rather than removing inconsistency, it will be introducing it in a manner that has potential for serious compromise to patient safety. The NZDA does not accept that OHT's have the knowledge, or the training required to safely treat adults independently.

The Association sincerely believes patients are best served if the diagnosis, treatment plan and informed consent are undertaken by a dentist and the clinical operative tasks with the current scope of OHT are then performed either by the same dentist, or under prescription from that dentist, by an OHT.

We propose the scope not be amended in the format described in the consultation document, but that it be amended in the same manner orthodontic elements of the OHT scope are currently written i.e.,

Current scope states-

Assisting the dentist or dental specialist in implementing orthodontic treatment plans, as directed by the dentist or dental specialist who is responsible for the patient's clinical care

outcomes and is on-site at the time, through performing the following orthodontic procedures:

Effectively, we are requesting the new scope retains that statement, but also contains a similar statement relating to extended age restorative elements e.g. in the same format add-

Assisting the dentist or dental specialist in implementing restorative treatment plans, as directed by the dentist or dental specialist who is responsible for the patient's clinical care outcomes and is on-site at the time, through performing the following restorative procedures:

2.2 Prescribed qualifications

If OHT's are to gain an extension into adult age group scope of practice it is incumbent on the Dental Council to ensure that they have received appropriate training to be competent.
In consideration of this, the NZDA believes it is appropriate to reflect on the entry requirements (particularly academic and other qualities via the UMAT) and rigor of the Bachelor of Dental Surgery course compared to that of the OHT course.

The NZDA is concerned about proposed new training pathways for OHT's and in the interests of public safety, it is essential to retain the supervision and clinical guidance and develop a prescriptive element.

We see the future very much being that of a dentist-led team approach to adult restorative care. Hence, in part, our preference to see OHT's trained in courses alongside dental students as being a requirement of course accreditation.

There are significant differences in the current education and training for OHT's and dentists and the scopes as they stand recognise this, with the requirement for supervision, or clinical guidance, for dental therapists practising the adult scope.

2.3 Public perception

As a lesser concern, there is also significant room for public confusion regarding the difference between the qualifications, skills and competencies for OHT's and dentists if an adult OHT restorative scope is introduced, and particularly if it is a scope that may be practised independently.

2.4 Competencies

The NZDA is extremely concerned that this proposal does not give adequate recognition to the complexity of adult treatment, particularly regarding diagnosis and treatment planning and the potential compromise to obtaining genuine informed consent. A real knowledge of the treatment modalities proposed as well as the benefits and disadvantages therein, considering an individual's particular circumstances, is required.

The NZDA does not believe this can be achieved safely without the knowledge and training provided within the Bachelor of Dental Surgery.

The specific areas of concern relating to competency standards without supervision by a dentist are as follows:

<table>
<tr><td>Analyse patient information and develop an oral health care plan</td><td>Recognise significant medical, dental and social history and develop the healthcare plan accordingly.</td><td rowspan="5">It is the strong view of the NZDA that these listed competencies (AS THEY RELATE TO ADULT RESTORATIVE CARE AND TREATMENT OPTIONS) can NOT be achieved in a safe manner without the knowledge and training provided by a Bachelor of Dental Surgery degree.</td></tr>
<tr><td></td><td>Develop evidence based, prioritised healthcare plans which include individualised strategies for: managing and preventing oral disease and its consequences.</td></tr>
<tr><td></td><td>Consider and discuss management options…..and anticipated outcomes.</td></tr>
<tr><td>Provide or make provision for oral health care:</td><td>Informed Consent
Provide patients, parents, or carers with full explanations and information to make informed choices</td></tr>
<tr><td></td><td>Restorative Intervention
Select the appropriate restorative procedure and dental materials</td></tr>
</table>

These areas of concern all relate directly to the limited extent of knowledge and training which must be the result of a shorter programme with very different areas of focus. The concern is that while the OHT may have the best of intentions, they “will not know what they don’t know”, which makes achieving the competencies listed above improbable without the direct supervision or clinical guidance / prescription of a dentist.

Q3. Do you have any further comments on the proposal?

Further to amending the OHT scope for the purpose of removing inconsistency between the dental therapy (adult scope) and the proposed extended oral health therapy scopes, the discussion document states the reasons for the proposal are to align practices in New Zealand with those in other jurisdictions e.g. the UK, Netherlands and Australia, as well as to make provision for a more flexible workforce.

3.1 International benchmarks

It is important that change is not made by simply following international benchmarks without priority consideration being for the current situation in New Zealand and the potential outcomes of that change.
It should at least be acknowledged that there are major differences between our funding of oral health care and that of the United Kingdom, Netherlands and Australia.
A recent review of hygienists and therapists working in direct access situations in the United Kingdom indicates that our concerns regarding sufficiency of training, dentist supervision, public perception and expectation, and unrealistic expectation of outcomes for public health are justified[1].

[1] Turner S, Ross M. Direct Access: how is it working? Br Dent J. 2017 Feb;222:191-97.

3.2 **Flexible workforce**

The Association is surprised that the Council has included statement and inference within the consultation document that 'strays' into workforce issues. It implies political pressure has been placed on the Council in an area (workforce) in which Council has always stated they have no role. Council, having raised the issue within the consultation document the Association wishes to respond as we suspect, in part, the considerations Council is contemplating unexpectedly and unwisely contain elements of workforce issues. The NZDA is very concerned that the proposed change as it stands will impact negatively on an already strained Community Oral Health Service (COHS), while at the same time having minimal impact on the stated intention of improving oral healthcare access and outcomes for the public of New Zealand.

There is very limited evidence regarding whether OHT's treating adults improves access, availability or decreases cost. What is available to date, shows that in America services provided to adults by therapists do not improve access, availability or reduce cost. The Australian Dental Association submission to the Dental Board of Australia on the Australian OHT scope of practice and independent practice states, the most comprehensive assessment from the USA reported "no evidence that the emergence of dental therapists has resulted in cost savings to the state, more equitable distribution of dental health professionals, or improved access to care for low income, uninsured and underserved populations[2].

There is however evidence that there has been for some time an oversupply of dentists in Australia which is expected to continue until 2025[3]. Exacerbating the flow on effect of this by adding OHT's into the mix has potential to create further workforce problems for New Zealand graduates of the future.

3.3 **Access to low income adult dental care**

It is suggested that removal of the age limit for restorative activities for OHT's could support initiatives to make access to primary oral healthcare easier for a broader group of patients.

The NZDA is very concerned that the proposed changes may have a serious and widespread impact on the oral health sector and in particular the oral health of the children of New Zealand, while at the same time having no discernible impact on the stated purpose.

There is an implication that extending the scope of OHT's will assist with addressing the significant degree of unmet dental need in the adult population. There is no evidence to support this and considerable risk that there will be serious impact on the provision of children's dental care.

At-need New Zealanders from low decile communities usually present with multiple, chronic and acutely infected teeth requiring extensive restorative, endodontic and surgical interventions. Potentially life-threatening infections from untreated carious teeth are not uncommon. Preliminary results from a study of patients seen at the *Revive-A-Smile* charity dental clinic in the Far North show that one in five patients required surgical drainage of an abscess to prevent spread of infection.

Furthermore, New Zealand has an ageing population with a steady increase of tooth retention into old age[4]. Many at-risk patients, and particularly those in the geriatric age bracket, take multiple prescription medications for a variety of complex medical conditions. Such patients often need prophylactic antibiotic cover and pre-treatment blood tests, to ensure they are medically fit to receive dental treatment. Their management requires careful planning and a multidisciplinary approach between dentists, dental specialists and general medical practitioners.

Oral lesions including pre-cancerous lesions are also more common among the elderly and patients of low socio-economic status. All New Zealanders should have the right to access care by professionals who are able to competently and safely diagnose, plan and manage their treatment needs. Providing OHT's with an independent adult scope would put already vulnerable patients at-risk of serious medical complications.

[2] Australian Dental Association submission to the Dental Board of Australia. 2018 May.
[3] HWA *Australia's Future Health Workforce 2025 – Oral Health* overview report. 2014 Aug.
[4] Thomson WM, Ma S. An aging population poses dental challenges. Singapore Dent J. 2014 Dec:35:3-8.

With respect to the provision of adult care there is already in place a trained, readily available workforce to care for the oral and dental diagnostic, restorative and surgical needs of adult patients in New Zealand. Why train another workforce to provide a limited range of treatments to adults when there is a workforce appropriately trained to treat the full range of problems the target group are likely to be experiencing? With regard to adult treatment the issue is the lack of funding, and overseas evidence has shown that the provision of adult dental care by oral health therapists does not reduce cost to patients, compared to care provided by dentists[5]. Nor does it increase access, or availability of treatment.

There is no evidence that the proposed extension of the OHT scope will contribute to the reduction of oral health inequalities in New Zealand. The public of New Zealand deserve the same level of expertise whether they come from high, or low socio-economic groups and regardless of their ethnic group.

3.4 **Community Oral Health Services**

OHT's play an essential role in the provision of preventive and restorative dental care for children and adolescents and oral hygiene services for adults, within their scope of practice.

The COHS is experiencing significant difficulty recruiting and retaining oral health therapists in many District Health Boards resulting in concerning arrears rates (approximately 100,000 children in arrears), increasing numbers of children requiring treatment under GA (more than 7000 annually)[6] and significant levels of unmet dental treatment need in our child population (40,000 children requiring extraction annually, a more than 10% increase on the previous year)[7] and DHB's with large numbers of children suffering untreated dental decay.

This problem is projected to become worse over the next few years as an aging oral health therapy workforce retires (50% in next 5-8 years). This problem will be further exacerbated by a move by OHT's to the provision of restorative dental care for adults.

Anecdotal evidence suggests inequalities in oral health are narrowing for children in areas where the COHS has a strong preventive approach[8]. The NZDA supports an expanding emphasis on oral health promotion and preventive care for child and adolescent patients and when considering workforce issues does not support initiatives such as the removal of the age limit for restorative care for OHT's, which will divert resources away from children's oral health and, in terms of current evidence internationally achieve no positive impact in other areas.

SUMMARY

The NZDA is grateful for the opportunity to comment on the consultation document provided by the Dental Council relating to the proposed removal of the age limit for restorative activities from the oral health therapy scope of practice.

1. The NZDA is concerned about the proposal as it stands and believes should the age limit be removed from the OHT scope, that the restorative treatments must be provided under prescription of a dentist, with that dentist having provided the initial diagnosis, treatment plan and informed consent. It is also our view that during provision of the clinical restorative care a dentist should be supervising, so that contingencies relating to treatment of deep dental decay can be provided immediately.

2. We were unaware that the Council had any mandate to consider workforce issues but, as they are mentioned within the consultation document, it is assumed that there is consideration being given to those issues as part of the consultation on removing age limit for restorative activities within OHT scope of practice. As such, we believe the extension of OHT's into restorative dental care for adults will further

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[5] Beazoglou TJ, Lazar VF, Guay AH et al. Dental therapists in general dental practice: an economic evaluation. J Dent Educ. 2012 Aug;76(8):1082-91.
[6] Hunt GR. Dental treatment of children under GA: a situational analysis. (Thesis, Master of Community Dentistry). University of Otago 2017. Available from http://hdl.handle.net/10523/7046.
[7] Ministry of Health. NZ Health Survey 2017-2018.
[8] Moffat SM, Foster Page LA, Thomson WM. New Zealand's School Dental service over the decades: it's response to social, political and economic influences and the effect on oral health inequalities. Front in Public Health. 2017 Jul;5:177.

impact adversely on dental services for children and adolescents (experiencing current significant workforce problems), whilst the suggested provision of restorative dental treatment for low-income adults (by OHT's) will not improve availability, access, or provide cost reduction.

3. The Association would be more comfortable regarding the removal of the age limit for restorative activities from the OHT scope of practice if accompanying prescription and supervision requirements were instituted concurrently. We have suggested wording (similar to the wording in the current scope relating to orthodontics) to describe these elements within the new scope.

Regards

David Crum ONZM
Chief Executive
New Zealand Dental Association