[redacted]

Page 2: Your demographics

Q1 Your details

Name	**Kate McElroy**
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

My concerns with these proposed changes lie across several broad themes:

1) The qualification of a BOH to become an 'oral health therapist' is in essence the degree you undertake in order to provide dental treatment to children and adolescents, and / or to provide hygiene therapy. If you want to provide care outside of this scope currently you undertake a dentistry degree in order to do so. This is not a 'hidden clause' when you undertake your initial study, it is clearly outlined by both the university and the dental council. I struggle to understand, why if your desire to treat in a wider scope is as strong, you do not undertake a dental degree in the first instance. Or if you decide that post training your desire to do more

so strong, you do not undertake a dental degree in the first instance. Or if you decide that post-training, your desire to do more within the field is so strong, why it is not strong enough to retrain appropriately, in its entirety, and do a dental degree subsequent to the BOH degree. To my mind this is no different to what any qualified dentist does, who wants to expand their scope into specialist practice.

2) Further to this, the entry criteria for a BOH degree and a BDS degree are very different. To undertake a BDS degree there is a rigorous selection process and extremely competitive entry from a prescribed first year general health sciences course; comparatively the BOH degree is non-competitive entry that can be accessed with considerably less in the way of academic achievement or ability. My concerns regarding this in relation to the proposed changes are
1) Students who are capable of doing the BDS programme secondary to the BOH programme, may well not do so. They have the ability to train into clinicians who could practice in every facet of dentistry, but will likely not do so as there is a broadened scope available within their existing qualification. So we lose the 'brightest' of the BOH cohort who are motivated, passionate and want to do more; worse, we will lose them into a lesser training pathway, that still has a limited scope, that will not gain the public or the profession any tangible benefits compared with what we have currently available. We should be actively encouraging these clinicians who are so passionate into further training to become dentists, not into a six month post-graduate diploma to do basic restorations in adults.
2) Students who were not able to gain acceptance to the BDS programme, may see this as an easier 'backdoor' to practice dentistry. So the students that were unsuitable, or not deemed academically capable of training to become a dentist will now be able to work on adults, all due to the merits of the short post graduate training stint?

As an aside to this, I already have significant concerns about the quality of dentistry being practiced within the scope of practice our oral health therapists currently have. I would think that further training within the scope may be more beneficial for many rather than further training outside of it.

3) One of the very emotive discussion points driving this push for an increased scope of practice, is the lack of affordability for many low income adults, to access dental treatment. Rumours abound currently at the ways in which an oral health therapist will be able to provide care for low income, high need patients in a cheaper and more accessible manner. However, in reality these claims are not backed up by international data where this model has been adopted or any feasibility studies. My concerns lie with the practical reality of whether the benefits presumed, will actually eventuate with the proposed changes:

1) These patients described as being those most in need of this proposal are the ones presenting with very complex medical and dental needs; requiring multiple, complex, deep restorations. Furthermore, this is usually compounded by requirements for endodontic treatment or extractions, both which will still sit well outside the scope of practice for oral health therapists.
Practically - of what use will the extended scope be, in the setting described, if an appointment is booked for a "broken tooth" - and that tooth requires extraction?
2) Oral health therapists treating adult patients will not necessarily result in cheaper dentistry for patients as the costs (sterilising, compliance, plant and equipment, consumables, and staff) for restorations will remain the same, irrespective of the operating clinician. Arguably you may be able to pay a therapist less than a dentist, but if they are providing the same service as a dentist would in a given situation, I anticipate that they will in time expect the same remuneration for it.
3) The issue is not one of a lack of practitioners and access in that respect, but one of affordability. Government support (financially) of dentistry for low income adults, would result in improved access to dentists, just as it would to an oral health therapist. There is no shortage of dentists, so why create another niche in the workforce when there is a fully trained one already present? The focus should be on finding a way to reduce the cost burden (e.g. co-payment) to the population most at need and unable to access care, rather than on creating another niche in the profession that is not needed.

4) It has been demonstrated that oral health services for adolescents and children (that are already state funded), are currently at crisis point and are struggling to cope with existing demand. This is predominantly driven by workforce attrition and an inability to recruit and retain new oral health therapists within the public system. Private practice (particularly in the hygiene scope of practice), already pays oral health therapists more, gives them increased flexibility in terms of work arrangements, and provides a less stressful work environment.
So are we going to lose these therapists with an extended scope to the private sector where price is not controlled, and the market will determine the cost? How will this improve accessibility to those in the most need?
Or if the public system steps up to employ these therapists with an extended scope of practice, how will the public sector recruit therapists to treat adults without cannibalising their existing employees from an already stretched service? Unless they will they pay them more - thereby negating all the 'savings' they have intended to make by hiring oral health professionals with limited skills and

less training than a dentist.

5) Finally, with regards to the postgraduate course proposed: there are no publicly known outlines that detail the specifics of the core course proposed (or any guidelines on what the NZDC will require as a baseline to accredit/certify a course within this scope). This is particularly concerning, as we have been told that this much touted course, will be what enables the postgraduate oral health therapists to attain the skills (and presumably adequate competency in these), to treat patients within the extended scope proposed.

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?	**Yes**

Page 7: Specific comments on the proposal

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

I do not believe that OHT scope of practice should be expanded to allow treatment of patients over the age of 18 years, in essence I oppose all of the proposed changes. Please see the previous comments.

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**